

**Expert Panel
Opioid Guidelines
Meeting Minutes
UDOH, CHB, Room 125
April 29, 2008
4:00-8:00**

Attendees:

Panel Member	Specialty	In Attendance
Jay Aldous	Dentistry	Yes
Marc Babitz	Primary Care, UDOH	Yes
John Barbuto	Nurology	Yes
Alan Colledge	Occupational Medicine	Yes
David Cole	Emergency Medicine	Yes
Mike Cruston	IHC	Yes
Robert Finnegan	Pain Management, UDOH	
Kathy Hogan	Primary Care, UDOH	Yes
Bob Rolfs	Internal Medicine, UDOH	Yes
Jerry Shields	Pharmacy	Yes
Roger Stuart	Occupational Medicine, Worker Compensation	Yes
Peter Taillac	Emergency Medicine, UDOH	
Lynn Webster	Pain Management	Yes

Support Staff	Bureau	In Attendance
Erin Johnson	Epidemiology, UDOH	Yes
Cameron Nelson	Epidemiology, UDOH - Intern	Yes
Iona Thraen	Patient Safety, UDOH	Yes
Nancy Williams	Occupational Medicine - Intern	Yes

- Covered Conflict of Interest Paper – reviewed the purpose of conflict of interest paperwork. Briefly discussed what a conflict might be.

Cameron Nelson

Covered the four guidelines being reviewed and a brief overview on how they were chosen.

GUIDELINES (4 DIFFERENT)

[1. ACOEM Guidelines \(section on Opioids only\)](#)

--nearly finalized for publication, appendix is still pending authorization on some items

[2. VA/DoD Clinical Practice Guidelines for the Management of Opioid Therapy for](#)

Chronic Pain

3. ASIPP's Opioid Guidelines in the Management of Chronic Non-Cancer Pain

4. Ontario's Evidence-Based Recommendations for Medical Management of Chronic Non-Malignant Pain: Reference Guide for Clinicians

--the complete guidelines were given to you in print form (only an abbreviated version is available online)

5. APS-AAPM Clinical Guidelines for the Use of Opioids for Chronic Non-Cancer Pain

--the guidelines anticipate final review in June and are not available for our use prior to pub

- Still don't have access to Oregon's guidelines. They will not allow an early release, won't be out until June 2008.
- For each guideline that was set, they were put into coordinating categories and then a grading scale was used for each topic (trial, documentation of medical records, etc.)

Question (John Barbuto) – Could we clarify what our focus is. It seems that these guidelines are taking the stance that all patients are “guilty” and already addicted.

Comment (Marc Babitz) - All the guidelines are geared toward chronic pain and don't address acute pain issues. We are trying to look for guidelines for chronic, not acute, non-malignant settings. This is a GUIDELINE, not a rule. Medical treatment and quality care guidelines that are scientifically and peer reviewed.

Comment (David Cole) – The guideline should require physicians to register and check the DOPL prescription drug database, check it when you have a new patient or as part of monitoring existing patients.

Question - Is there a way that the database that can updated more frequently and not just every 30 days?

Answer - This is scheduled to be done in 2009.

Alan would like to have the committee review the Washington State Guidelines and the Federation Guidelines – Even though they were not one of the original ones chosen. It has some applicable items we should consider.

- Addresses how to wean someone off medication
- Allows requirements to be added
- It is a guideline that has been implemented not just one that “might” be implemented

Other ideas

- E-mail the federation guidelines
- USE the TOC as a guide on how we anticipate the guidelines will look
- We want something that is readable, usable, and workable
- Washington's guidelines include the conversation table
- Includes a referral process.

- ◆ The problem with the Washington Guideline is that there are not enough specialist to handle the referrals

PROPOSAL - Alan Colledge

We have available a good sampling of models to review. Would like to include the Washington and Federation proposals

SECONDED – Dave Cole.

- Iona will get those two proposals to the group.

We will look first at the areas listed, discuss and define definitions.

Comprehensive Patient Assessment

Guideline to address: Chronic Non-malignant Pain Patient

- Define Chronic – that depends on how we use that term.
 - ◆ Does it include past history or just what the patient is there for?
- We don't need to tell them how to do the physical, we need to tell them what to focus on. Chief comp., family history
- We need to help the doctor ask the right questions as part of their 99203

Recommendation: Each doctor is billing according to the CCPT if you are billing for a 99203 or 99204 there are very specific criteria. Follow this for the patient assessment.

Question: Is the ER the place you deal with chronic pain?

Answer: No. In the ER you are dealing with an acute problem. Then get them over to another physician.

POINTS

Point One:

Organize this assessment around the CCPT, focusing on drug history and psychiatric functionality:

- Does your pain prevent you from doing your job and outside activities
- Who is managing the household
- Active daily living questions:
 - ◆ Does the medication allow you to do that
- Past history of drug abuse.
- Checking the DOPL database.
- At least a 99203, but could be a 99204.
- There is some diagnosis made
 - ◆ not just words, what is the path of physiology diagnosis
 - ◆ not a symptom diagnosis
- Include sleep apnea

Point Two:

Screen for the risk of addiction or abuse – Once your assessment has been completed, if you have a chronic pain patient.

How you treat a patient at risk. This would be how you treat and monitor them.

- Recommend SOAPP or
- Opioid Risk Tool
- Consider utilizing UA (which includes prescribed meds
 - ◆ common lab will not detect most synthetic opioids – include specific list
 - ◆ medical opioid screen

Question – by requiring some of these tests are we causing an insurance problem?

Response (Marc Babitz) - We will work with Medicare and then other insurance plans.

Point Three:

Treatment Goals

- Functional improvement (quantifiable) Psychological or thereapeutic – Let the practioner decide this
- You need to look at a treatment plan to improve the condition, not just alleviate the pain
- Needs to be quantifiable
- List tools that can be used to measure treatment
 - ◆ Must be kept up-to-date
- Engage the patient in their own treatment or own health

Point Four:

Informed Consent and Agreement

- Permission to discuss with family (Federation Guidelines examp)
- 1 MD
- 1 PHARM
- Risk benefit
- Exit plan that discloses if the patient fails to have functional improvement or exhibits unsafe habits that are harmful to the patient or provider.
- Include the Law on giving fraudulent information
- Include that their name will be input into the DOPL database when they fill their prescription
- Include possible non-family members can be contacted to discuss how they view your functional improvement
 - ◆ by name (specifically) (**verify legal issues**)
 - ◆ will not discuss confidential information, but to make sure improvement is being made

Point Five:

Initiate Trial and Opioid Therapy

- If the decision is made to use Opioid therapy
- Evaluate not only the trial, but how will you stop the use if it doesn't work
- The least amount of medication for the best result
- Effective therapy that has either a decrease in pain or improvement in functionality.
- Reevaluate the patient
- Asking about pain relief isn't enough; this is not a justification to continue the medication.
- Keep in mind that you may have a patient that is functionally impaired, but there are ways to determine if there is an improvement in pain (vitals)
- Fewer adverse events (awake more, interacting with other, watching TV, etc)
- Use the treatment goals to help determine the trial

Types of Drugs

- Unsafe use of long acting drugs unless development of opioids, use short acting
- Follow-up every two weeks at least
- List concerns/warning of prescribing long acting drugs
 - ◆ Safe keeping
 - ◆ Lock boxes
 - ◆ Be specific how you are prescribing, minimize PRN. List what a daily maximum is.

Point Six:

Titration Phase

- Assuring functionality (physical and psychological)
- Adjustment of dosage
- MUST go slowly. Low dose, increase slowly
 - ◆ despite patient demands
 - ◆ assess weight
 - ◆ type of pain
 - ◆ condition
 - ◆ age
- Footnote that states these are not meant for in-patient care
- Educate patient that the need to follow the schedule to keep pain manageable
- Don't use with opioid naïve patient
- 2 wk of 60mg Morphine equivalent (duragesic)
- You have failed the trial on a drug if you have intolerable effects. You can then move to another opioid. Either back-down the usage or try another opioid.
- If you change the treatment, then make sure that you evaluate the monitoring necessary.

Point Seven:

Periodic Review and Monitoring

- Monitoring of DOPL database
- Aberrant behavior
- Random drug screen
- High risk
- Function
- Pain relief
- Side effects (FOUR A's)
 - ◆ analgesia,
 - ◆ activities of daily living,
 - ◆ adverse side effects,
 - ◆ aberrant drug-taking behaviors
- Strong consider the checking of DOPL database
- Assess how they are doing in their function
- Revisit path of physiological hypothesis, why is it still valid.
- Review how a prescription is written
 - ◆ Can or/will you give a script with a refill.
- Frequency of visit should be based on risk stratification and physician judgment (psychiatric condition)
- Volume of medication and abuse ability of medication

Point Eight:

Consultation

- Path of physiological diagnosis verification
- Management of risk

Point Nine:

Documentation and Medical Records

- What should be documented – document the four A's
 - ◆ What are you going to do about it?
- Document height, weight, and vital signs and making sure you are looking at the whole patient
- Reassess medical condition
- Class three felony to give fraudulent information to medical personnel

Point Ten:

Adjust Therapy

- Verification of other sources
- Four A's
- Diversion

- ◆ No other prescriptions
- Legal Evidence of diversion
 - ◆ notify authorities
- Another MD can report a crime – unless you are substance abuse clinic
- If you notice that you are treating the same patient as another doctor, you can call and notify that doctor about that item.

Acute Pain

- Amount prescribed
- Diversion
- Amount needed
- Dispose of properly

Acute Pain from ER / Dental

- Use short acting opioid

- Briefly covered the matrix on how success will be monitored.

Wiki:

Google.com/account and create an account.

Sign in, choose docs. You have access to the TOC and the expert panel draft. Making edits, go to file and then revision history. You can choose compare. This will allow you to see the changes and who made them.

RULES:

- No deletions
- No formatting changes
- Only additions
- Add comments if you want to propose a deletion
- Indicate by adding your name and brackets what your recommendations are.

ACTION ITEMS:

- Washington State Guidelines
- Federation proposal
- verify legal issues as noted in Point Four

Would like to have a final document ready by May 20th meeting.