

**Prescription Pain Medication Program  
Steering Committee  
February 17, 8:00-10:00**

**Vanguard 2009**

- TV spot “Long Nap” currently running on 3 local TV stations
- Movie Theater ads at the District currently running as added value. Paid spots begin running May 4-17 (coincide with release of X-Men and Star Trek blockbusters).
- Updated website: radio spot now runs when you go to the home page.
- Media campaign evaluation will begin end of May.
- Working to post the TV spot on YouTube.

Discussion:

Idea to add Interaction Checker to website:

Is there one that is accurate that we can link to?

Epocrates has a checker available to the public (lists drug interactions, but not related to doses)

Downside: may create undue concern/patients become oversensitive and worried even when it is ok

Upside: healthy discussion for patients to have with their docs/docs can learn all the meds a patient is on

Pharmacology.com may have one

Could HI develop a card that has all the meds that affect the QT interval? Could be handed out to docs.

Chart to hand out to docs that they keep easily visible that tells about drugs that interact with opioids

Need to make it easy for public to access

Do a blitz with information

Kim: email slides on QT prolongation to Perry Fine for comment and suggestions for improvement

Erin: send Kim Arizona State/University site with QT information (used in guidelines)

Enlist Vanguard to make a forward-looking plan with thoughts of how and when to do PSA's and news pitches (schedule)

**HealthInsight**

- 406 people have attended presentations
- 163 docs have completed first survey
- Well-received
- Docs stay awake and don't leave early
- Docs leave wanting more information

Discussion:

Fine: similar experience in California where CME's on opioids were required—people enjoyed and learned from it even though they were skeptical about the requirement to begin with

Alan: having UMIA work together with you would be helpful

\*We should all be on the lookout for opportunities to get on agendas of meetings

### **CDC Grant Application**

- Applied Jan 23
- Purpose: evaluate Opioid Guidelines
- ~\$275,000
- Will hear end of May
- If awarded, begins in September

### **Research at OME**

- 102 of 250 identified cases have interviews completed
  - ~137 OD cases identified
  - ~60 OD cases have been interviewed
  - 44% of possible OD cases have been interviewed
  - ~4 refused
  - ~20 can't get good contact info
- Most people who have been contacted have been willing to interview
- Will be collecting medical records to see if this gives valuable additional info

### **Guidelines:**

Concise summary of comments

- > 80 comments – public, clinicians, pain sufferers and family
- Clinicians – overall supportive and indicated it will be welcome
- Public
  - Concerns about introducing barriers (drug testing, required referrals, cost)
  - Concerns about impact of addiction
- Special consideration
  - Recommend sleep testing
  - Require peer consult before opioid trial
  - Limit threshold dose (120mg) – overall limit or require consult above threshold
  - Don't set dose threshold
  - Don't require failure of other treatments first
  - No use of short-acting for breakthrough pain
  - Recommend against use in adolescents
  - Shouldn't apply to hospice, palliative care, etc.

Major changes

- Many editing changes suggested and incorporated to clarify
- Recommend sleep apnea caution and consider testing

- Recommend caution and increased vigilance above 120-200 mg
- Reworked wording on use of other modalities first
- Clarified guidelines don't apply to hospice, etc.
- Changed recommendations for drug testing from all patients to consider for all patients and perform when any reason for concern, with explanation of value.
- Strengthened message regarding importance of evaluating trial before committing to long term treatment, including recommendation that referral may help with decision
- Strengthened message regarding risk of transition from acute pain treatment to chronic treatment
- Added caution regarding adolescents to recommendations on acute pain
- Clarified that an adequate trial of alternative treatment before using opioids can have been conducted by a previous provider.

#### Next steps

- Submitted to Dr. Sundwall for approval.
- Sent to panels for final review
- Format, publish on web and paper form

#### Questions:

- Process to keep up to date?
- Dissemination methods?

Annual conference for Labor Commission on May 14<sup>th</sup>—Alan will discuss the guidelines.

Guidelines include Chronic and Acute, but sub-acute was never addressed. Perhaps in the next version this will be included.

\*Update guidelines to include Rep Daw's bill

\* Make sure Rep Daw is recognized in guidelines

\*Erin send a new version to Alan

\*Alan send wording about Labor Commission's contribution

\*Any deviation to this guideline should be documented. The art of medicine is recognized. But sometimes exceptions become the rule. These guidelines are meant to improve outcomes. Departures should be well justified and documented.

\*Put public comments up on web (available)

Ideas for keeping up the guidelines:

Anniversary meeting

Choose a panel (maybe same people/maybe new group) to meet periodically

Send email out to panel to give time for them to prepare/collect literature to bring to the meeting

Reference guidelines at the top of bibliography

\*check for consistency on non-malignant vs. non-cancer (pg 31) (use non-cancer)

## **CSDB**

- Commerce hired someone to: improve interface and increase usage
- Willing to accept feedback
- Will be doing trainings on new interface

Nothing on the license test that talks about the CSDB

~20,000 possible people who could access the CSDB. 2,544 registered users.

## **Other Discussions:**

1. Have a weekly public health corner or set up part of the news that does health related articles. To make a difference, needs to be in the same place each week. Healthy Utah has taken over.  
Check Your Health  
Baby Your Baby  
Tom Hudacho has access to all the info
2. Preferred Drug List (meeting tonight). May restrict use of formulary only (which would, by default, mean that people would prescribe more methadone).

Our program can make a suggestion/recommendation to change what is on the PDL to ensure it is consistent with the guidelines. Should have concordance between PDL and the guidelines.

Because of economic factors, more people will be using methadone (with fewer people able to afford insurance).

We should be moving away from methadone as a first-line drug

3. Requiring CME's that are specific to opioids in order to receive CS license  
At the time of relicensure, 6 questions (submitted by us) that must be answered on opioids/controlled substances.

Six slide ppt that has to be read before getting relicensed

Kim/Terri: send us some questions from your survey that may be used as these questions

Alan: when it comes from UMIA, you get the docs' attention

4. Need for surveillance: Is there ongoing database that looks at NSAID morbidity to see if that is increasing as we shift away from opioids? Concern that as we shift people from one class of drugs they always move to another.

Interaction between NSAIDS and acetaminophen: found that there is a significant interaction (published in JAMA).

5. Erin: check on BRFSS ? for next year