
Bree Collaborative | Opioid Guideline Implementation WorkgroupNovember 13th, 2019 | 3:00 – 4:30**Foundation for Health Care Quality**705 2nd Avenue, Suite 410 | Seattle, WA 98104

MEMBERS PRESENT

Jason Fodeman, MD, MBA, LNI

Gary Franklin, MD, MPH, (Co-Chair) Medical Director, Washington State Department of Labor and Industries

Negar Golchin, PharmD, MPH, (for John Vassall, MD, FACP) Comagine Health

Cyndi Hoenhous* and Rose Bigham, Washington Patients in Intractable Pain

Andrew Saxon*, MD, (Co-Chair) Director, Center of Excellence in Substance Abuse Treatment and Education (CESATE), VA Puget Sound Health Care System

Andrew Friedman,* MD, Physical Medicine and Rehabilitation Virginia Mason Medical Center

Pamela Stitzlein Davies,* MS, ARNP, FAANP Nurse Practitioner Departments of

Neurology & Nursing, University of Washington

Gregory Terman,* MD, PhD, Professor Department of Anesthesiology and Pain Medicine and the Graduate Program in Neurobiology and Behavior, University of Washington

Jaymie Mai,* PharmD, Pharmacy Manager, Washington State Department of Labor and Industries

Mark Stephens, President, Change Management Consulting

David Tauben, MD, Chief of Pain Medicine University of Washington Medical Center

STAFF AND MEMBERS OF THE PUBLIC

Erin Henderson,* Alliance Pain Center

Alex Kushner, Bree Collaborative

Ginny Weir, MPH, Bree Collaborative

Lauren Lyles*, Executive Director, Pharmacy Commission

* By phone/web conference

CHAIR REPORT & APPROVAL OF MINUTES

Gary Franklin, MD, MPH, Medical Director, Washington State Department of Labor and Industries, and Ginny Weir, MPH, Bree Collaborative welcomed members to the workgroup and those present introduced themselves.

A quorum was not reached for the approval of meeting minutes from October 16th, 2019.

DEVELOPING DRAFT RECOMMENDATIONS: ASSESSMENT

The workgroup viewed the Draft Chronic Opioid Management Assessment and discussed:

- Changes to make to Pathway #2: Taper or Wean
 - The text for this entire section will be replaced with the HHS guidelines for tapering.
 - These guidelines were deemed excellent by the group.
 - Group would like to add— to the HHS guidelines— that behavioral health needs to be available to everyone who is experiencing chronic pain.
- Rose Bigham, of Washington Patients in Intractable Pain, requested that a 4th pathway be added to the guidelines: a pathway for patients who have need of opioids, do not possess risk factors, and who do not currently have access to opioids. This pathway could also apply to those who have been taken off of opioid treatment (and do not possess risk factors) and who could benefit from resumption of treatment.

- Workgroup agrees that, while this is an appropriate pathway to consider, it should be tabled until the group has finished work on the three current pathways that are already in progress.
- Group circles back to discussing Pathway #2: Taper or Wean
 - When the group decides to add anything to the HHS guidelines, it must make sure not to contradict the guidelines.
 - Adding new, non-contradictory, recommendations is fine.

Action Item: Keep Pathway #2: Taper or Wean, but remove text for this section and replace it with the HSS guidelines.

- Group discussed *Health Systems Interventions*.
 - Group clarifies that this section is meant to make recommendations for both delivery systems and payment systems.
 - The guidelines should address billing codes. Group to add recommendation that health systems should write a billing code for 3 to 4 hour sessions (to support robust assessments that are being recommended).
- Buprenorphine and its uses are discussed:
 - HHS guidelines recommend that, if a patient has OUD or if they meet criteria for taper but are having severe withdrawal, buprenorphine can be useful.
 - Group agrees that the report needs added clarity on the uses of buprenorphine and when to use it.
- EHR systems are discussed as a possible tool:
 - Studies have shown that EHRs have almost no effect on important outcomes like death and overdoses.
 - However, group agrees that report should still include best practices for EHR.
 - Gary Franklin mentions that a survey he did demonstrated that having best practices embedded in EHR helped practitioners maintain treatment with their patients.
- Group discussed inclusion and exclusion criteria for the three pathways. Group agreed that it would be worth writing Pathway #1 as the converse of the HHS list that will be used for Pathway #2. Changes made to Pathway #1:
 - “Opioid dose is < 90 mg/day MED” is removed.
 - Bullet beginning with “Has a destructive disease process...” is removed.
 - The first bullet, beginning with “Clear evidence of...” is removed but incorporated into the opening instructions for pathway #1. This line is to be rewritten as “Consider maintain and monitor quarterly if the patient shows *WAC Language defining clear evidence of improvement*.”
 - “No significant side effects that impair function and impact quality of life” is added as a new bullet.
 - Add a specific timeframe to “No recent history of alcohol misuse...,” i.e., five years.

Action Item: Group agrees to do more research on “No history of opioid misuse or diversion.” Group will also return to discussion of the bullet beginning “Opioids are not principally prescribed for a centralized pain conditions....”

- Group briefly discussed how opioid prescribing should interact with cancer-related pain management. Group agreed to come back to this discussion at a later date.

GOOD OF THE ORDER/OPPORTUNITY FOR PUBLIC COMMENT

Three members of the public gave comments recounting difficulties in accessing comprehensive pain care. The workgroup explained the scope and purpose of the recommendations to members of the public. Dr. Franklin then thanked all for attending and adjourned the meeting.

DRAFT