
Bree Collaborative | Opioid Guideline Implementation WorkgroupJanuary 29th, 2020 | 3:00 – 4:30**Foundation for Health Care Quality**705 2nd Avenue, Suite 410 | Seattle, WA 98104

MEMBERS PRESENT

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

Charissa Fotinos,* MD (Co-Chair) Deputy Chief Medical Officer Washington State Health Care Authority

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

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

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

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

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

Mark Stephens,* President, Change Management Consulting

STAFF AND MEMBERS OF THE PUBLIC

Ginny Weir, MPH, Bree Collaborative

Alex Kushner, Bree Collaborative

Jason Fodeman, MD, MBA, LNI

Katerina LaMarche, Washington State Medical

Association

Brooke Evans and Abby Berube, Washington State Hospital Association

* 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. Last meeting's minutes were not reviewed.

REVIEW OF CHANGES MADE TO DRAFT RECOMMENDATIONS: ASSESSMENTS

The workgroup viewed the Draft Chronic Opioid Management Assessment and discussed the changes that were made during and after the last workgroup. The group began by viewing the Develop a Treatment Plan section:

- The section on complex persistent dependence was moved out of the main text and into the appendix.
- "Medication assisted treatment" was changed to "medications for opioid use disorder".
- Language from the WAC guidelines was added to the third paragraph and to the bullet points in this section.
- Third bullet added: Involve behavioral health providers, where possible. The bullet also includes useful language.
- "Alcohol use disorder" was changed to "substance use disorder".
- Discussion was had about including "cannabis use disorder" in this list, but the group agreed that it would not have any specific recommendations in this regard.
- "These diagnoses should be treated as needed" was added to the behavioral health bullet in order to clarify that the alleviation of pain is not expected to treat these other conditions.

- The “useful language” bullet points were deemed confusing and unnecessary; the bullet points were deleted.
- “Intermittent steroid injections” was removed from the “use non-opioid pharmacological pain management” bullet.
- “Sleep hygiene” added to the “non-pharmacological pain management” bullet.
 - A final bullet is added to this section: “Use a treatment agreement that includes all necessary and agreed upon requirements...”
- The group decided to move the language in the final paragraph of this section regarding the 2019 HHS Guideline to a side-bar in order to highlight it.
- The group reviewed the “Maintain and Monitor” section:
 - The group discussed “Opioids are not principally prescribed for a centralized pain condition...” — this is not phrased as a criteria for using this pathway. The group agreed to move this language to the tapering section of the document.
 - The group agreed that maintain and monitor needs to mention functional status and life role status, added a bullet: “Pain, function, and life role status have been meaningfully improved as described by the patient (e.g., playing with grandchild)”
 - The group discussed whether or not to soften or change “Not on combinations of opioids and sedatives”.
 - A concern was raised about people who have anxiety and chronic pain. However, combining sedatives and opioids even in very small doses is extremely dangerous.
 - Some group members thought that an exception could be made for occasional use with proper patient counseling.

ACTION ITEM: Dr. Tauben will talk to Dr. Mark Sullivan to get language for softening this line in a safe way.

- The group changed the bullet beginning with “No unexpected...” to “No pattern unexpected controlled substances on PMP or unexpected results from UDT”. This allows for a patient who occasionally loses meds or needs to get more before traveling.
 - The group substituted “history” for “pattern” in the next bullet for the same reasons.
- The group discussed “No history of opioid misuse or diversion” and decided to change that bullet into two bullets. Now one bullet reads “No history of diversion”—diversion is always a red flag. The second bullet reads: “No pattern of problematic opioid use.”
 - The group discussed referring to Table 9 in Appendix X at the end of the above bullet; instead, they decided to make a new table with the most common aberrant behaviors as Table 9 is from 2006.

ACTION ITEM: Create a new table of the most common aberrant behaviors to be added directly after the bullet beginning “No history of opioid misuse or...”; Jaymie’s chart in the appendix summarizing the pathways will need to be updated based on changes that were made in this meeting.

- The group moved on to the “Tapering” section.
 - A question was asked about including language with specific instructions for reducing dosage, including possibly adding a specific number for the minimally effective dose. However, there is no agreed upon dosage amount in the literature and amounts depend on the individual; therefore, the group was not comfortable making a recommendation in this regard.

- Bullet beginning with, “Tapers may be considered successful...” is moved up to become the first bullet of the “Tapering” section because it clarifies what a successful taper entails.
- The workgroup will add in a box that includes the HHS recommendations for special populations and managing tapering.
- “Medication Assisted Treatment” is changed to “Medications for opioid use disorder” throughout the document.
- The group discussed the “Medications for Opioid use disorder” sub-bullet:
 - The group discussed whether or not the “Complex Opioid Dependency” section should be included in this bullet (it is currently in an Appendix). The concern of making it more central to the document is that introducing a new term would stigmatize those who fall into this new category.
 - Counter argument was made that the goal of the classification is to distinguish between dependence and opioid use disorder and to make sure medications can still be covered under a diagnosis code.
 - The group wants to make sure that insurance companies will pay for Buprenorphine when it needs to be used for tapering patients who are dependent but do not have use disorder.
 - To encourage buprenorphine to be covered even without an opioid use disorder diagnosis, the group changed the first sub-bullet in this section to end with “may indicate the need for a trial of medications for opioid dependence which may not meet criteria for opioid use disorder.”
 - This whole sub-bullet was also moved into the tapering section.

GOOD OF THE ORDER

Dr. Franklin thanked all for attending and adjourned the meeting.