

## Alaska Opioid Policy Task Force Meeting Notes

July 8, 2016

Dr. Jay Butler convened the meeting at 9:02 a.m. He welcomed the group and introduced the topic, Pathways to Addiction.

Kate Burkhart called the roll.

Gunnar Ebbesson offered opening comments, appreciative of the information being shared with the task force members, particularly the [National Governor's Association Roadmap](#). That will be very useful. Dr. Butler agreed that the NGA Roadmap will be helpful, and that this task force is looking aligned. He also mentioned the [National Safety Council rating](#), which gave Alaska a 1. He feels that might be a generous rating but he's confident that in the next 6-12 months Alaska will be a 3-4 (out of 5). Dr. Butler also said he'd heard that CARA (the Comprehensive Addiction and Recovery Act) had passed the House of Representatives

Dr. Butler commented that today's topic is important because of the changes in practice over the past 20 years. He introduced the first speaker.

### **Dr. Deborah Hastings, MD, Centers for Disease Control and Prevention, Center for Injury Prevention and Control**

Dr. Hasting is a board certified internist working with the Center for Injury Prevention and Control.

Why did CDC develop the guideline? Approximately 11% of Americans experience chronic pain and primary care providers, though reporting insufficient training, prescribe 50% of all opioids for pain. The amount of opioids prescribed has quadrupled, though reports of patient pain haven't.

The previous guidelines were more than five years old and didn't include new research or evidence – particularly research related to dosage and risk of overdose. The new guidelines are specific to primary care providers treating adults for chronic pain. They are not meant for palliative or cancer care providers.

Additional Information:\*

- [Why Guidelines for Primary Care Providers? Infographic](#)

Dr. Hasting described the GRADE review process for evaluating evidence and making recommendations. The CDC looked at recommendations with an eye to whether they would do more good than harm. (See page 7 of the [presentation](#).)

\*Additional information, noted with a ➤, was not provided during the presentation. It is provided here for the benefit of task force members and the public.

The clinical review found that there is no long-term outcome in pain or function after 6 weeks. The rate of dependence in primary care pain patients of 3-26%. Methadone was associated with higher mortality risk.

- [An overview of the research and evaluation](#) related to the guidelines was published by the CDC in the Morbidity and Mortality Weekly Report on March 18, 2016.

Dr. Hastings walked through the 12 recommendations (page 17-31 of the presentation).

Question and Answer:

Jeff Jessee asked if the CDC is collecting data about prescriber compliance with the guidelines (baseline and over time) – and how Alaska might evaluate compliance.

Dr. Hastings: States can use the Prescription Drug Monitoring Program (PDMP) to look at providers' behaviors. An [institutional review board](#) might be needed for an in depth study. The CDC is developing their efforts to evaluate the implementation of the guidelines – she can provide additional information. The CDC is not a regulatory agency, but it can look at data and report on it. The guidelines are not regulatory – they are a starting point for clinicians.

Rep. Seaton commented that there was significant pushback from Alaska's medical community about legislating standards of care (re: 3/7 day prescription limits). Does the CDC have experience with other states effectively incorporating these guidelines in state law or regulation?

Dr. Hastings: Clinician pushback is understandable, but the research shows 3-7 days is an appropriate length of time in the majority of cases. She will check with CDC policy leads to see if they have more information.

DBH staff member Lynn Eldridge asked if these guidelines were just for outpatient providers. Dr. Hastings answered yes

Ray Michaelson asked about guidance for other classes of pain medication.

Dr. Hastings: The recommendation is for providers to better utilize non-opioid medications for pain.

Christina Love: What about Suboxone for chronic pain management?

Dr. Hastings: It can be used that way, and is an alternative if the provider has the experience and expertise to prescribe it.

Dr. Simon: Reimbursement for non-opioid alternative pain medications is not always covered by insurance. Is CDC advocating with agencies to help get those medications covered?

Dr. Hastings: We see that as a significant issue. However, the CDC can't advocate for legislation. The CDC can provide evidence and data. That is an area that does need addressing. She will follow up with CDC's policy section.

Dr. Simon: Is there a public education process, so that patients understand why doctors are making the pain management recommendations they are making. Helping people in pain understand the risks and downsides of opioids addresses one of the drivers of the problem.

Dr. Hastings: Yes, the CDC website has some information and it is trying to reach the public more actively.

- [CDC Guideline Information for Patients](#)
- [Prescription Opioids: What You Need to Know](#)

Dr. Butler: Regarding the use of opioid pain medications in sports medicine – the CDC used to have a relationship with major league/professional sports. Is there conversation about using that relationship to reach down to amateur, youth, and college athletes to educate them?

Dr. Hastings: That relationship has focused on brain injuries, but she will see if there is conversation about opioids.

- [Painfully Obvious: A Longitudinal Examination of Medical Use and Misuse of Opioid Medication Among Adolescent Sports Participants, Veliz, P. et al. Journal of Adolescent Health \(March, 2014\)](#)

Gunnar Ebbesson raised concern that the recommendation for treatment for opioid dependence is medication assisted treatment (MAT) first or only, without any consideration of psychosocial treatment. He described situations where people would benefit from detox followed by psychosocial treatment rather than lifelong medication. He commented that there is need to increase the efficacy of psychosocial treatment and not rely solely on MAT. He recommended more balance in recommendations from federal policymakers.

Dr. Hastings agreed that some patients can be treated and supported without MAT. If it's coming across as the CDC recommending MAT as the first choice for opioid dependence treatment, the CDC needs to adjust that message (and she'll follow up with her organization).

Dr. Simon: Is there a timeline for providing continuing medical education?

Dr. Hastings: No, but there is a host of information on the CDC website for prescribers. They also have webinars and clinical outreach calls.

- The CDC Clinical Outreach and Communication Activity information and schedule is [online](#).
- Upcoming calls related to opioid prescribing are July 27, 2016 – CDC Recommendations for Non-Opioid Treatments in the Management of Chronic Pain; and August 3, 2016 – Assessing Benefits and Harms of Opioid Therapy for Chronic Pain.

### **Dr. Daniel Hartman and Melissa Merrick, Southcentral Foundation**

Southcentral Foundation's (SCF) guidelines are evidence and research based, growing out of its clinical utilization review systems. SCF had systems in place, but still lacked consistency across providers. Managing pain is a difficult area for providers, who consistently asked for more training and support.

The SCF guidelines were developed by a multi-disciplinary team of physicians, pharmacists, physical therapists, behavioral health providers, and “dental from time to time.” They were implemented two years ago.

The SCF guidelines are very similar to the CDC guidelines. They were reviewed when the CDC guidelines came out, to see where they differed and if they needed to be adjusted. For example, SCF started with a higher upper limit (120 mme) and brought that down to 90 mme (what CDC recommends). SCF also adjusted its guidelines to recommend immediate release over long acting opioids.

Consistency, safety, efficiency are the desired outcomes from the SCF guidelines. They had identified internal doctor-shopping as an issue, so the guidelines were meant to prevent that. SCF did not limit the formulary but did work to increase use of other non-opioid medications. SCF pulled in supports for the primary care providers from other departments and the integrated behavioral health consultants (BHC).

SCF requires a meeting with the BHC before the prescription of opioids for pain management. That BHC does a pain assessment which includes risk factors for substance abuse.

There is an Opiate Review Committee that reviews patient cases involving long-term pain medications. They will review for signs of abuse or diversion and respond when necessary. Providers are trained in having difficult conversations with patients, to help maintain the therapeutic relationship while addressing risk.

Patients in pain management sign controlled medication agreements and wellness care plans. All patients receiving >500 pills in 6 months, or 90 days of consecutive prescriptions, or who are prescribed 90mme/day must sign a medication agreement. This plan helps manage care across departments, and allows for data analysis by SCF management.

Pain management patients must also have to have a wellness care plan, which addresses behavioral factors, non-opioid treatments for pain management, and wellness. It's an agreement between patient and prescriber, so it has to be redone if the person switches doctors. SCF also uses patient education materials to promote informed consent.

SCF discourages prescribing more than 90mme, and cases with higher doses require review by the Opioid Review Committee. Some patients are deemed ineligible for opioids by the Committee, and prescribers should not prescribe to them (without individual review and exception).

SCF is tracking the data related to all controlled medications (not just opioids). They can drill down to who prescribed, how much, how often, etc. They can identify patterns, and allow for connecting with prescribers when needed. SCF shared the way they track provider behavior and the quantities of opioids prescribed. Since 2014, the quantity of opioids prescribed has decreased significantly.

Dr. Hartman: "We work hard with our clients to help them, and we do not fire clients." Referencing the prescribing trend data, "we treat people humanely, with true relationship building, and it's working."

Merrick: SCF avoided hiring a pain specialist for a long time, but based on providers' requests for better training and support, they hired Dr. Karen Nelson to consult with the patient care teams on pain treatment. Primary care providers send their hardest cases to her. Often the clients have co-morbid mental health conditions, but aren't engaged with the BHC on their primary care team or the behavioral health department. SCF works to capitalize on motivation when the patient has it, and patients seem to respond better to Dr. Nelson when it comes to setting boundaries.

Dr. Hartman: Our clients have the benefit of other services – chiropractic, behavioral, wellness, other non-pharmacologic services – regardless of cost (because they are in a single payor/IHS system, rather than dependent on insurance). They also have better access to neurologic, orthopedic, other specialty services. It works well, though it is costly to run.

Dr. Hartman: Many patients choose to use less or to taper off of opioids.

Merrick: The guidelines were the last piece of SCF's opioid protocol, to support and educate providers, not to constrain them. They encourage the providers to use it to educate patients (not just say "the guidelines say I can't").

Kim Zello: Does SCF have a suboxone program?

Merrick: Suboxone has been a challenging service. SCF had a "champion" (provider) of the service, and they tried unsuccessfully to expand the provider base. When the champion left, they had no Suboxone prescribers. SCF is able to take referrals and is slowly bringing the

service back on line. They expect all the psychiatrists co-located in primary care to get Suboxone waivers, and then to match patients to them for services. It's a slow roll out.

Dr. Coleman: He helped move the Suboxone from a stand-alone service to an integrated service with the patient care teams. He reiterated that the goal is to have MAT patients shift back to primary care after 8-16 months of stability. They will need to work closely with ANMC so that patients on Suboxone are appropriately treated in the emergency room, for surgery, etc. (especially as the population grows).

Woods: What is SCF doing to protect elders receiving opioids from elder abuse/ predation/ diversion? The challenges is rural clinics are unique . . .

Dr. Hartman serves a clinic on the Peninsula. There is no region not affected.

Dr. Butler: What is the role of hospital administrators in prevention of opioid misuse/abuse/ diversion?

Merrick: SCF leadership vetted all the guidelines – to help them understand what the clinical team wanted to do and build buy in. Hospital leadership need to understand the challenges prescribers have in pain management, so they can support the providers and endorse a holistic approach to wellness (so the non-opioid/non-pharmacologic options are included). Also, they need to have a perspective that it's about wellness and not punishing addicts. Dr. Coleman added that open communication is essential between administrative leadership and medical leadership.

Byron Macynzski: Lisa Murkowski has asked him to provide recommendations for policy change related to opioids. He has asked her to send specific questions by email, which he'll share with task force members for a response.

Jessee expressed appreciation that SCF integrated behavioral health and insured access to that resource in their guidelines. He can see that the outcomes in the CDC guidelines would be hard to reach without those behavioral health resources. Merrick agreed. Integrated behavioral health helps educate providers on the co-morbid mental health and substance abuse issues that patients experience. Including other disciplines (pharmacy, nursing) is equally valuable. Dr. Hartman added that it would be hard to achieve these results without the wellness services. From a policy perspective, it's incumbent upon prescribers to build the relationships with the other services in the community. Many physicians don't have those skills, nor are they reimbursed to do that work. Also, they aren't trained in motivational interviewing and these patient conversations are very difficult. Motivational interviewing training is a core component/precept to this response.

## Task Force Discussion

Dr. Butler asked if task force members have policy recommendations in mind based on today's discussion. He asked Rep. Seaton about the Homer data that was shared. Rep. Seaton explained that was Medicare Part D prescription data for opioids (relevant for older/Medicare patients). Is there something we can do, use it to examine prescribing patterns, educate providers? He sent it to Homer providers but hasn't gotten feedback.

Merrick: Health care systems should be looking at their practices, and the PDMP can be a source of trend data.

Dr. Coleman: There are private health analytic companies that can look at data from electronic health records. Oregon is doing that with their data from coordinated care organizations. Dr. Hartman added that Washington has a well-developed data analytics effort. The Washington prescription drug monitoring program (PDMP) is bidirectional (Alaska's is not). Institutions' use of data is specific to each organization's need and culture. At SCF, providers are receptive to use of data to improve practice.

Dr. Butler: SB 74 enhances the PDMP and allows use of data as an epidemiological tool to address some of Rep. Seaton's questions.

Ebbesson: What does the PDMP legislation say?

Butler: SB 74 reflects the Controlled Substances Advisory Committee recommendations. All prescribers with DEA numbers must register with the PDMP. All prescribers must check when prescribing a schedule II or III medication (unless it's an emergency, for inpatient care, etc.). It allows delegation of access to another licensed provider in the practice. It makes updates weekly (they were monthly). It adds access to the Medicaid Pharmacist to help with fraud, waste and abuse; and the medical examiner, to help investigate suspicious deaths; and public health (de-identified data only) to support epidemiological efforts. They are effective 7/2017 and sunset 7/2021 – so metrics/evaluation are key.

Erin Narus commented that patient safety is also a big issue. Medicaid has set limits on quantities on opioids, so some doctors started writing two prescriptions instead of one to circumvent the limit. So it's not just about Medicaid policy, it's about reducing risks to Medicaid patients and targeting outreach to recipients and providers.

Rep. Seaton: What do we do to address the prescribing patterns? The information is interesting but what will we do with it

Ebbesson noted the CDC recommendation to prescribe naloxone rescue kits for patients getting high opioid doses. He would extend that to providers of Suboxone and Vivitrol treatment, give the higher risk of overdose when tolerance is lost. He also stressed the need for family caregiver training on naloxone, citing the higher risk of overdose among older

opioid patients. Dr. Butler agreed, noting that not all providers know of that heightened risk.

**Public comment:**

**Lauri Struthers, mother**

She appreciated being able to attend the meeting. Her son's addiction started after a tonsillectomy, when he couldn't manage his pain. He went looking for oxycontin on the street to help with the pain. That led to the usual pattern of stealing, criminal activity. He got caught, was on probation, and kept violating his probation. There is no treatment in the prison or halfway house in Fairbanks. She has asked the courts, probation officers for help. Treatment would prevent him from going through the revolving door. He's been through outpatient treatment, and when he was receiving Suboxone there was no referral for psychosocial treatment (which she thinks is very important). Has there been progress with treatment programs in DOC? Access to treatment during incarceration to reduce recidivism is essential.

**Theresa, mother**

We had a great conversation with the Police Chief in Fairbanks about how we can't arrest our way out of the problem. We need more interventions and treatment. She is the mother of someone addicted to opiates. They need interventions and then a place to go for treatment and help. No mother should have to go what she went through.

Dr. Butler thanked them for their testimony and reminded everyone that this is why the task force is doing this work.

**Sullivan Summit Planning Discussion:**

Kate Burkhart described the planning process that Senator Sullivan's staff have engaged in. Task force members discussed possible break out session. Tina Woods said that, based on her meeting with the Senator's staff, they were interested in the unique challenges of rural Alaska. For example, the short duration of Naloxone and how it would be administered in bush Alaska while waiting for a medevac.

Ebbesson moved that rural issues be a break out topic. Narus suggested telehealth and access to treatment. Woods agreed, given the providers needed to offer MAT. Narus followed with opportunities for the federal government to make it easier for rural patients to get MAT.

Jessee agreed – we need to tell them what they can do administratively, legislatively to solve these problems. Give the Senator a “to do list” at the end. We could ask SCF for input.

Dr. Coleman: Integration is important. It allows access to care where they are (not just in behavioral health) – and because it lives in the heart of primary care (prescribing opiates). Reimbursement is a barrier, though.

Ebbesson suggested coming up with a list ahead of time. Burkhart reminded that Macynzki asked for help responding to Senator Murkowski. It should be a uniform list. There seemed to be consensus that they wanted to do that in the next few weeks.

Christina Love suggested break-out sessions on the CDC guidelines and recovery pathways.

Jessee: Ensure that issues of certification as MAT providers is a break out.

Burkhart will send task force members an email of broad themes and possible action items for task force members to comment on by end of business Thursday.

The meeting adjourned.