

**Prescription Pain Medication Steering Committee Meeting
October 9, 2007**

Present:

Diana Baker
Martin Caravati
Alan Colledge
Teresa Garrett
Craig Povey
Robert Rolfs
Doug Springmeyer
Mitchell Jones
Iona Thraen
Erin Johnson
Kim Bateman
Guests: Joel Millard & Marc Babitz

Next meeting: Nov 20 from 9:00-11:00 in room 401 (please RSVP if you can not come)

1. Additions to Steering Committee:
 - a. Representative Brad Daw (honorary member; will attend whenever possible)
 - b. Perry Fine, MD, Pain Research Center
2. Funding:
 - a. Still waiting to hear back about Blue Cross Blue Shields offer to see if it will defray costs already put in the budget
3. Marc Babitz: Expert Panel for Guidelines Development
 - a. Identified expert panel members:
 - i. Robert Finnegan
 - ii. Doug Smith (IHC)
 - iii. 1 Dentist: Jay Aldrous or Robert Soderberg
 - iv. 1 Oral Surgeon: Karl Lind, Grant Cannon, or Roger Adams
 - v. Kathy Hogan, FNP
 - vi. Alan Colledge
 - vii. Ed Holmes
 - viii. Martin Caravati
 - ix. John English
 - x. Michell Leifson
 - xi. John English
 - xii. Ben Buchanan (ER)
 - xiii. Nurse Practitioner
 - xiv. Physician Assistant
 - xv. Linda Tyler (pharm)
 - xvi. Ric Coleman (pharm)
 - xvii. Retail pharmacist organization
 - xviii. Roger Seward
 - b. Need to check with UMA to see if they want another representative

- c. Linda Tyler may have suggestions for content expert (since she was content expert for Medicaid preferred prescriber plan)
 - d. A reactor group of practice-based prescribers will be organized that will respond to the guidelines that are put together by the expert panel and make their own suggestions. After much discussion, it was determined that in order to gain buy in, the practice prescribers will serve to validate the evidence as implemented in real world settings.
 - i. This should have a balance of urban/rural, small clinic/large clinic, private practice, and substance abuse treatment docs.
 - e. Evidence based recommendations will be summarized by staff based on expert panel review and discussion and then provided to the practice implementation group for feedback and implementation recommendations.
 - f. Consensus is desired, but as the recommendations will represent UDOH, Dr. Sundwall will review and make final set of recommendations.
 - i. A consensus process will be identified, written down, and explained to groups at the beginning. Conflicts and differences of opinion will be noted as either unresolved, minority positions, or overruled with a 2/3 anonymous vote.
 - g. Content expert:
 - i. Feedback from steering committee indicated that the content expert should be kept separate from the expert panel.
 - ii. As she is being contracted for and paid as staff, she will present her findings to the group and then will be asked to do additional research on topics needing more clarification and/or where gaps are identified.
 - h. Guidelines should include declaration of conflict of interest disclosure, funding sources, and method used to identify inclusionary criteria for the evidence based articles
4. Joel Millard: Methadone Clinics
- a. 2,000 people on methadone treatment in Utah
 - b. 3 for-profit: Colonial (Bountiful, St. George, and Logan), Discovery House (SL, Taylorsville, Orem, soon Layton), Metamorphosis (SL, Ogden)
 - c. 1 not-for-profit: Project Reality (Provo, SL)
 - i. Philosophy: treat to prevent withdrawal symptoms not to manage pain. Also, combine treatment with therapy
 - ii. Patients come in seven days/wk (can see when they have relapsed)
 - 1. no more than 6 take-home doses given at a time
 - 2. some methadone clinics give 30 days
 - iii. Many with co-occurring illness: depression, bipolar
 - iv. Treat in integrated way—all the needed staff available at one location (also, partner with Utah Valley Mental Health for chronic cases)
 - v. Induction process: no more than 30mg the first day (risk losing people seeking treatment because the dose is too low to be effective, but it is too risky to give a higher dose)

- vi. “Start low, go slow”
- vii. Once tolerance is established, the methadone dose does not need to be increased overtime
- viii. Zero tolerance for admitting patients who use benzos
- ix. Goal is for individuals to be functional/able to work
 - x. The population of those seeking treatment is very diverse
 - xi. Joel feels that most addicted kids first obtained Rx drugs from cabinets
 - xii. Joel offered to add questions about the source of drugs to the patient satisfaction survey he administers
- 5. Legislative Report: you will be able to review this before we report
 - a. Interim day is Nov 14; it is likely we will report to Business & Labor Interim Committee this day
 - b. Less is more
 - c. Don’t promise what you can’t deliver
 - d. Show how this is a good investment to the committees
- 6. Update on CSDB:
 - a. Working toward MOU with UDOH & DOPL to set up access to the CSDB data for analysis. Meeting will be held with leadership and IT support to discuss strategy of getting this done.
- 7. Update on Advisory Committee:
 - a. ~50 attendees
 - b. Added 4th Work Group: Data/Research/Evaluation
 - c. Work Groups will meet monthly
- 8. Next meeting agenda:
 - a. Craig Povey or other Substance Abuse representative involved in phone study research that asks about the source of prescription drugs
 - b. Rehearse legislative report (report will be given to the Health and Human Services Interim Committee the next day)

Action Items:

- 1. Iona: talk with Val Bateman at UMA to see if they want more representation in the expert panel. Coordinate a way for a UMA representative to report back to the UMA about our meetings.
- 2. Doug: meet with Erin and Iona to discuss possible processes for agreement among the expert panel
- 3. Craig: report on the phone study being done at Substance Abuse (or coordinate to have a guest come to report to us) for November 20
- 4. Erin: invite Rep Daw to interim committee presentations