

**DRAFT MINUTES**  
**QUALITY IMPROVEMENT AND PATIENT SAFETY**  
**COMMITTEE MINUTES**  
**September 20, 2018**  
**Via Webex and Teleconference**

**Quality Improvement & Patient Safety Committee**

Willie Underwood, Chair, MD, Chair, *via telephone*

Maria Basile, MD, *via telephone*

Clare Bradley, MD, *via telephone*

Patricia Gagliano, MD, *via telephone*

Mustafa Kaakour, MD, *via telephone*

Roy Korn, MD, *via telephone*

John Ostuni, MD, *via telephone*

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**1. Welcome and Roll Call**

**2. Approval of Minutes**

The minutes of May 24, 2018 were unanimously approved.

**3. Presentation by Nancy Nielsen, MD, PhD, Senior Assistant Dean for Health Policy, Jacobs School of Medicine and Biomedical Sciences – “The Physician’s Role in Treating Pain in an Opioid Crisis”**

**WNY Crisis 2016 – Pain Clinic Shut Down**

- Law enforcement action: resulted in over 9500 pts, many on chronic opioids, who suddenly had no access to care.
- Almost 40% were WC pts, and many physicians refused to participate in WC. Physicians were legitimately afraid of being the next one indicted, of using high dose opioids, of being flooded with drug-seeking patients,
- ERs would only treat for 3 days; some refused care to these patients (a clear EMTALA violation).
- There were many admissions for withdrawal, several suicides and at least 3 presumed OD deaths from street drugs.

**What Did We Expect to Find:**

- 35-year old guys who didn’t want to go back to work.
- Drug-seekers and drug abusers.
- Polypharmacy.
- Inattention to warning signs of abuse.
- Inattention to dangerous drug interactions.
- Poor record-keeping.

**What Did We Find:**

- Polypharmacy. The morphine equivalent per day was very, very high.
- MED were often high patients stable.
- Extremely good records.
- Tight monitoring, random urine tox, pill counts.
- Rare aberrant behavior (cocaine, MJ or alcohol abuse).
- It looked like Lourdes, without the good outcome.
- Patients were overwhelmingly grateful for help.

### **Patient Demographics:**

- Many were older and some had walkers or were in wheelchairs.
- Drug dependence was universal.
- Substance use disorder criteria were met in a small minority.
- Patients were "medical refugees" and frightened.
- Huge majority had post-op failures or complications.
- Most had other physicians, some who washed their hands due to complexity of medical needs.
- Quite a few had a behavioral health problem.

### **So How Did We Get Here Anyway:**

- Ramped-up law enforcement and regulatory activities. A doctor who writes a lot of opioids is on the radar screen of law enforcement.
- Pain practices have become a dumping ground for complex, difficult cases (and a magnet for those with SUD.)

**CDC Guidelines for Opioid Rx of Chronic Pain:** A quick summary of what was issued in 2016 after extensive study, literature review and stakeholder input.

- Use other modalities when possible.
- Use immediate release formulation opioids rather than LA or ER.
- Use lowest dose possible for therapeutic benefit.
- Limit MMEs to less than 50/day if possible with a ceiling of 90/day (should justify the increased risk when doses are 100/day or more).
- Avoid concurrent opioids and benzodiazepines due to risk.

### **Feds Have Acted:**

1. FDA black box warnings on both short and long-acting opioids back in 2016.
2. Our Health Commissioner urged all physicians to consider becoming trained to use buprenorphine in MAT.
3. HHS has three approaches to help us prescribe more judiciously to increase naloxone availability; increase access and use of MAT for opioid substance use disorder.
4. Recent Open Door HHS Forum on federal opioid strategy. Dr. Nielsen participated in this forum and stated that this was a very good one but there was one comment from the FDA that I wanted to call to your attention. The FDA representative noted that the FDA is planning to develop guidelines for how many opioid pills should be issued per procedure.

### **State Efforts to Limit Opioid Prescribing:**

- Massachusetts. The BCBS limited the days it could be used and then state legislated it and New York has done the same and has mandated clinician education.
- New York's 7 day limit for initial script (cancer and chronic pain not affected by this limitation).
- I-STOP is a good thing but it creates more work for offices. It has dramatically reduced doctor-shopping and opioid prescriptions in New York. Forty-nine states have PDMP, only Missouri doesn't.

Dr. Nielsen said that the DOH and OASAS for the state have put together an Advisory Committee and there was a meeting a couple of months ago in Albany. One of the issues that came up the state agencies posed some questions to us. They wanted to know if they should take the seven-day limit down to three-days and the consensus was no. We did suggest that it might be helpful if we were to prescribe three-days with a refill. Whether that will be possible or not, we don't know.

### **So WNY clinic reopened, but...**

- We need to markedly reduce use of opioids for acute or post-op pain.
- County med society/specialty societies drafted acute pain guidelines.
- All regional ERs agreed on 3 days Rx's for acute pain.
- UB Ortho convened all orthos to voluntarily share medical practices.
- Roswell Study: GYN oncology surgeons severely restricted opioids.
- Implementing SBIRT training in all residencies.
- Work with patients who have chronic pain to improve function.
- Need multi-disciplinary assessment/referral center for chronic pain.

- Why? (if you're a hammer, everything is a nail) How to sustain this model financially?
- NY statewide pain management committee ó advice to government regulators as they consider more actions (further limitations, etc.)

**What Else is Needed:**

- Pain fellowships, addiction med fellowships and palliative care fellowships do not interact now.
- Evidence base for complementary medical therapies needs to be strengthened and publicized.
- Insurers need to weigh current costs of care against coverage of complementary approaches.
- Physicians need to help regulators and law enforcement get it right and (we have initiated and maintained communications with the DEA, the US Attorney, the DOH and the BNCS.)
- Huge need for CME programs that are practical and deal with their everyday life.
- Let's work together to see how best to improve function and safety. *Workers' Compensation remains problematic.*

Dr. Lee agreed with Dr. Nielsen on the comprehensive and regional pain management programs. He noted that he spoke at one of the public sessions for regulating marijuana and spoke to the perception that we are merely switching one synthetic or natural drug for another in much of our societal policy in public health. Dr. Nielsen said that we were very concerned about our rush to approve medical marijuana for chronic pain and for opioid use disorder. There is preliminary data about that. Dr. Nielsen states that as she talks to large hospital systems in Western New York, pain management is largely done ad hoc by the attending physician. There is not a coordinated pain service in either of the major systems and she is interested in knowing if that is happening in your area. It also has to be a fiscally sustainable thing. Moe asked if there was a plan for the statewide pain management committee to meet again? Dr. Nielsen said that they send us requests for information but she is not sure whether they are going to re-convene us. Moe said that from a MSSNY standpoint we were pleased that it was a very physician heavy composition, including several physicians who work very closely with MSSNY in the past. Dr. Nielsen said it became pretty clear to her that they wanted input from the Governor whether he was going to put anything into action that he would ask the legislature to act on. Most of the discussion was much more open and she would say much more interesting on what we need and how we have to help people with chronic pain and not leave them as the "medical refugees" we had here in Buffalo years ago.

**4. Report of the Long Term Care Committee:**

Dr. Lee made the presentation for Dr. Slotkin. He discussed the educational presentation to the Long Term Care Committee on elder abuse. The purpose help detect and educate caretakers, as well as to have a scientifically based program to improve the environment for elders. It was proposed as a voluntary program, with no government mandate which is a good start. He stated that there are still some holes in terms of detection and the proper diagnostic workup.

Moe said that Dr. Pinto raised the idea of having Department of Aging staff go out to medical society meetings across the state and promote this screening protocol. It seems there is a lot of interest given the fact that this is something that physicians in various practice settings would come across, whether it's an office, a hospital or a nursing home or if they are providing a home service. They want to get our feedback if in any way we see that it does not seem appropriate or could be added. Dr. Slotkin made the suggestion that perhaps not only this be done in intake but it also be done in discharge planning in hospitals when it might be a further identification where there could be some elder abuse taking place. We will continue to follow up with the DOA on this matter.

In addition Dr. Kaner gave an update on the End-of-Life Task Force that was created as an outgrowth of the interest on the issue of physician assisted suicide. MSSNY certainly has a variety of perspectives. The group is continuing to meet. There was also recognition that regardless of the general time frame for the committee to put together a written report, the beginning of the legislative session would potentially bring about some need to, if there is some kind of additional further refining of MSSNY's position. We also talked about trying to create a permanent elimination of the mandate for e-prescribing for nursing homes. As the committee knows, since 2016 you have been required to send prescriptions electronically. One of the exceptions that has been put forth on a year-to-yearly basis has been for prescriptions for patients in nursing homes rather than kind of going on this year-to-year approach. The NYS Association of Medical Directors has advocated for legislation that creates a permanent exemption to the mandatory e-prescribing law and they are working with the various associations to gather support for that legislation. It did pass the senate this year and began to move in the Assembly but did not pass.

We talked briefly about the October 3<sup>rd</sup> Sepsis. That is the next item on the agenda for this committee.

**5. Discussion of Changing Meeting Date for 2019:**

There was discussion on changing the meeting date to Wednesday afternoons. The consensus was that all members were in agreement.

**6. Next Meeting and Adjournment:**

To be determined.