



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MIKE ZIMMER
DIRECTOR

**MICHIGAN BOARD OF OSTEOPATHIC
MEDICINE & SURGERY
April 7, 2016 MEETING**

APPROVED MINUTES

In accordance with the Open Meetings Act, 1976 PA 267, as amended, the Michigan Board of Osteopathic Medicine and Surgery met on April 7, 2016 at the Ottawa Building, Conference Room 4, 611 West Ottawa Street, Lansing, Michigan 48933.

CALL TO ORDER

David Walters, D.O., MHSA, Chairperson, called the meeting to order at 9:00 a.m.

Members Present: David Walters, D.O., MHSA, Chairperson
Susan Sevensma, D.O., Vice-Chairperson
Steve Ebben, Public Member
James Kilmark, PA-C
Sheri Thompson, Public Member
David Waterson, D.O.

Members Absent: Jennifer Cory Behler, D.O.
Kathryn Hoover, Public Member
Kathleen Kudray, D.O.
Diane Parrett, D.O.

Staff Present: Erin Londo, Board Support, Board and Committees Section
Michael Siracuse, Policy Analyst, Board and Committees Section
Kiran Parag, Analyst, Compliance Section
Michele Wagner-Gutkowski, Assistant Attorney General
Thomas Clement, Assistant Attorney General
Forrest Pasanski, Manager, Pilot Program to Reduce Overprescribing

APPROVAL OF AGENDA

MOTION by Sevensma, seconded by Ebben, to approve the agenda as presented.

A voice vote was taken.

MOTION PREVAILED

APPROVAL OF MINUTES

MOTION by Sevensma, seconded by Kilmark, to approve the February 4, 2016 meeting minutes as presented.

A voice vote was taken.

MOTION PREVAILED

REGULATORY CONSIDERATIONS

Chris Robert Farnum, DO – Proposal for Decision

MOTION by Sevensma, seconded by Ebben, to accept the Proposal for Decision with a correction to the last paragraph on page 8, to read "...in good faith to be restored to the privilege of practicing osteopathic medicine and surgery." Petitioner is granted a full and unlimited license. Petitioner is placed on probation for one year with quarterly female chaperone reports.

Discussion was held.

A roll call vote followed:

Yeas:	Ebben, Kilmark, Thompson, Waterson Sevensma, Walters
Nays:	None

MOTION PREVAILED

CE REVIEW

No CE was reviewed by the Board.

OLD BUSINESS

NONE

NEW BUSINESS

Overprescribing

Thomas Clement, Assistant Attorney General, addressed the Board regarding the overprescribing problem facing the State. In his presentation, he addressed three main ways to combat the problem: education, legislation, and MAPS. The Governor has formed a task

force and the Attorney General is working with the task force to make policy recommendations. Professionals should review guidelines and the literature issued by the State and use MAPS to access information regarding those individuals creating the problem. A press release has been issued regarding overprescribing. The Board should review the on-line press releases at least monthly. (See addendum #1)

The Board supports the work being done by the State on the issue of overprescribing.

Process for Assigning Compliance Conferences

Chairperson Walters confirmed with the Department that the process for assigning compliance conferences is for him to randomly assign them to participating physicians. Walters will handle the compliance conferences that take place in Detroit.

Department Update

Siracuse reported that the AOA and ACGME are combining into one agency. The application will be corrected to reflect this.

MOTION by Thompson, seconded by Sevensma, to recognize that ACGME residencies are substantially equivalent to AOA residencies.

A voice vote was taken.

MOTION PREVAILED.

Siracuse also reported that the rules went to public hearing and there were no comments. He will circulate the rules to the Rules Committee and a final version will be presented to the Board at the next meeting.

The Rules Committee consists of Sevensma, Walters and Thompson.

Bureau Director, Kim Gaedeke introduced herself and updated the Board on the database changes that are forthcoming in the Bureau.

PUBLIC COMMENT

None

ANNOUNCEMENTS

The next regularly scheduled meeting will be held on June 2, 2016 at 9:00 a.m. at the Ottawa Building, 611 West Ottawa Street, Upper Level Conference Center, Conference Room 4, Lansing, Michigan.

ADJOURNMENT

MOTION by Kilmark, seconded by Sevensma, to adjourn the meeting at 10:02 a.m.

A voice vote was taken.

MOTION PREVAILED

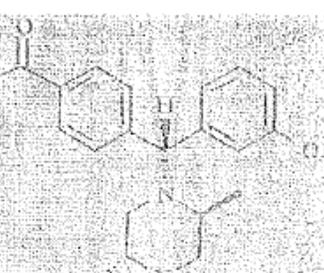
Minutes approved by the Board on April 7, 2016.

Prepared by:
Erin Londo, Board Support

April 12, 2016

Addendum #1

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN



IMPROVING PRACTICE THROUGH RECOMMENDATIONS

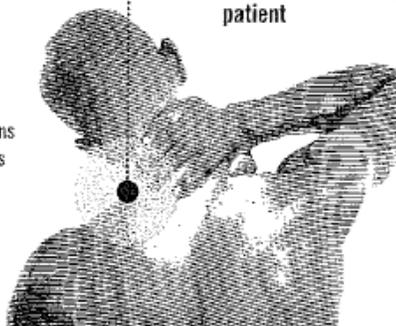
CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

- 1 Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
- 2 Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
- 3 Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

- 4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
- 5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.
- 6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
- 7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

- 8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.
- 9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
- 10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
- 11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
- 12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed



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 Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html