



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MIKE ZIMMER
DIRECTOR

**MICHIGAN BOARD OF MEDICINE
MARCH 16, 2016 MEETING**

APPROVED MINUTES

In accordance with the Open Meetings Act, 1976 PA 267, as amended, the Michigan Board of Medicine met on March 16, 2016, at the Ottawa Building, Conference Room 3, 611 West Ottawa Street, Lansing, Michigan 48933.

CALL TO ORDER

Peter Graham, M.D., Chairperson, called the meeting to order at 10:07 a.m.

ROLL CALL

Members Present: Peter Graham, M.D., Chairperson
Luis Avila, J.D., Public Member
Michael Chrissos, M.D.
Michelle Gormas, P.A.
Sandra Howell, M.D.
Renee Johnston, Public Member
Kara Morley-Smolek, M.D.
James Rogers, M.D. (arrived at 10:14 a.m.)
James Sondheimer, M.D.
Dennis Szymanski, M.D.
Terri Tahnoose, Public Member
Rosalie Tocco-Bradley, M.D., Ph.D

Members Absent: Mohammed Arsiwala, M.D.
Richard Bates, M.D.
Stacey Frankovich, Public Member
Lisa Huta, Public Member
Louis Prues, Ph.D, Public Member

Staff Present: Erin Londo, Board Support, Board and Committees Section
Michael Siracuse, Policy Analyst, Boards and Committees Section
Michele Wagner-Gutkowski, Assistant Attorney General
Thomas Clement, Assistant Attorney General

APPROVAL OF AGENDA

MOTION by Howell, seconded by Tocco-Bradley, to approve the agenda as presented.

A voice vote was taken.

MOTION PREVAILED

APPROVAL OF MINUTES

MOTION by Szymanski, seconded by Johnston, to approve the January 20, 2016 meeting minutes as presented.

A voice vote was taken.

MOTION PREVAILED

REGULATORY CONSIDERATIONS

None

COMMITTEE REPORTS

Investigations and Allegations

Rogers reported that the Investigations and Allegations (I&A) Committee reviewed twenty-five (25) files in February 2016. Eleven (11) files were authorized for investigation and fourteen (14) files were closed. There were three (3) reviewers.

In March 2016, the I&A Committee reviewed 27 files. Fourteen (14) files were authorized for investigation and thirteen (13) files were closed. There were four (4) reviewers.

Disciplinary Subcommittee

Johnston reported that the Disciplinary Subcommittee (DSC) met today and considered fourteen (14) matters: twelve (12) Consent Orders and Stipulations, one (1) Administrative Complaint and one (1) Proposal for Decision.

Chairperson's Report

Graham reported that he handled eleven (11) conferee assignments, nine (9) sanction recommendations, three (3) complaints, two (2) compliance conferences, four (4) summary suspensions, two (2) CME, eight (8) monitoring and two (2) miscellaneous matters.

Graham reported to the Board that Member Pasky has resigned her position.

Graham will be unable to attend the FSMB. Arsiwala will attend in his place.

OLD BUSINESS

None

NEW BUSINESS

Continuing Education

MOTION by Szymanski, seconded by Johnston, to table the CE program applications until the next meeting.

Discussion followed.

A roll call vote was taken.

Yeas – Howell, Johnston, Rogers, Szymanski
Nays – Avila, Chrissos, Morley-Smolek,
Sondheimer, Tahnoose, Tocco-Bradley,
Graham
Abstain - Gormas

MOTION FAILED

Andersen Eye Associates

MOTION by Sondheimer, seconded by Tocco-Bradley, to approve the CE program application.

Discussion followed.

A roll call vote was taken.

Yeas –Gormas, Morley-Smolek, Tahnoose,
Tocco-Bradley, Graham
Nays – Avila, Chrissos, Howell, Rogers,
Sondheimer, Szymanski
Abstain – Johnston

MOTION FAILED

MOTION by Gormas, seconded by Johnston to table the Andersen Eye Associates CE program application until the next meeting to allow the applicant an opportunity to provide more documentation and complete the application.

Discussion was held.

A roll call vote was taken.

Yeas – Avila, Chrissos, Gormas, Howell,
Johnston, Morley-Smolek, Rogers
Sondheimer, Szymanski, Tahnoose
Tocco-Bradley, Graham
Nays – None

MOTION PREVAILED

MOTION by Sondheimer, seconded by Rogers, to remove the application for CE approval from website and to have the Bureau stop accepting such applications until a procedure is put into place.

A voice vote was taken.

MOTION PREVAILED

Michigan Public Health Institute

MOTION by Howell, seconded by Tahnoose, to approve the CE program application.

A roll call vote was taken.

Yeas – Chrissos, Gormas, Howell,
Johnston, Morley-Smolek, Rogers
Sondheimer, Tahnoose
Tocco-Bradley, Graham
Nays – Szymanski
Abstain – Avila, Johnston

MOTION PREVAILED

David Leichtman

MOTION by Szymanski, seconded by Chrissos to deny the CE waiver application. The Board considered the application justification for renewal request insufficient.

Discussion was held.

A voice vote was taken.

MOTION PREVAILED

Chaldean American

MOTION by Rogers, seconded by Sondheimer, to approve the CE program application.

Discussion was held.

A roll call vote was taken.

Yeas – Gormas, Howell, Morley-Smolek, Rogers,
Sondheimer, Tahnoose
Tocco-Bradley, Graham

Nays – Chrissos, Szymanski

Abstain – Avila, Johnston

MOTION PREVAILED

Overprescribing Problem

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. Professionals should review guidelines and the literature issued by the state and use MAPS to access information regarding those individuals creating the problem. (See addendum #1)

Department Update

Siracuse reported that the rules are going to public hearing March 23, 2016. Public comments can be made through email for 24 hours after the hearing.

PUBLIC COMMENT

Miha Todd addressed the Board regarding the difficulty navigating the allegation process.

ANNOUNCEMENTS

The next regularly scheduled meeting will be held on May 18, 2016 at 10:00 a.m., at the Ottawa Building, 611 West Ottawa Street, Upper Level Conference Center, Conference Room 3, Lansing, Michigan.

ADJOURNMENT

Chairperson Graham adjourned the meeting at 11:33 a.m.

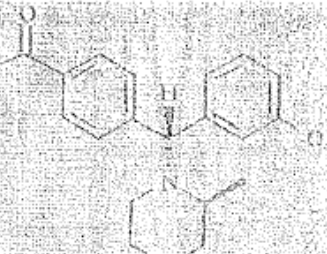
**Minutes approved by the Board on May 18, 2016.

Prepared by:
Erin Londo, Board Support

March 17, 2016

Addendum #1

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN



IMPROVING PRACTICE THROUGH RECOMMENDATIONS

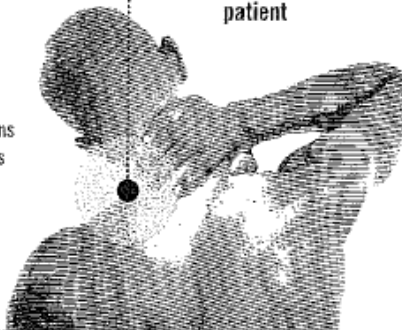
CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid 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.htm

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

CLINICAL REMINDERS

- ④ Use immediate-release opioids when starting
- ④ Start low and go slow
- ④ When opioids are needed for acute pain, prescribe no more than needed
- ④ Do not prescribe ER/LA opioids for acute pain
- ④ 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

- ④ Evaluate risk factors for opioid-related harms
- ④ Check PDMP for high dosages and prescriptions from other providers
- ④ Use urine drug testing to identify prescribed substances and undisclosed use
- ④ Avoid concurrent benzodiazepine and opioid prescribing
- ④ Arrange treatment for opioid use disorder if needed



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

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