New Mexico Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council

June 22, 2018 1:30 – 3:30

Scientific Laboratories Building

1) Introduction and Review of Agenda
2) Approval of Minutes
3) Senate Bill 29 Board Position Additions: addiction specialist, dept of public safety, hard reduction specialist, Human services dept and third-party payer
4) Council attendee speaks out: One participant feels that the council is harming patients by restricting opioids. She will not
5) Pain Survey Results: (preliminary)
    a) NMDOH Substance Abuse Epidemiology Section developed the chronic pain module questions from the Behavioral risk factor survey system January and June through December. 4000 NM adults people answered the survey, over the phone, both landline and cell phone, random selection. 31% had chronic pain and 29% has had chronic pain for >10 years. Of those, 50% had no impact on their ability to work.
    b) Cause of pain: Arthritis 20%, back pain 21%, injury 12%, neuropathic 7%; fibro, HA, unk, muscle pain, DM, cancer, shingles all less that 5%,
    c) Medication use: Those with chronic pain, 20% use OTC and Rx opioids. 15% used medical marijuana. 7% used alcohol.
    d) Other therapies: 20% used PT, 4% used acupuncture, 19% massage, 24% natural supplements, 8% used TENS unit.
6) Integrative treatment presentations:
    a) Acupuncture: Auricular acupuncture. One study showed 10% improvement in pain, another study echoed those same results. Another study looked at spinal cord injury neuropathic pain shows a positive increase but the study is a little suspect. Review of 15 RTC shoed AA decreased pain intensity, esp for chronic LBP and HA but lasting effects not proven. Another study, 9 participants, decreased their pain by 80%. While the studies aren't rigorous, many of the accepted therapies in chronic pain also lack rigorous study results. Therefore, it is considered an accepted therapy for the treatment of chronic pain.
    b) Chiropractic: in NM, chiropractors can order studies, diagnose, treat and refer. Chiropractor treatment includes but not limited to spinal manipulation, electrical stimulation, trigger point injections, limited prescriptions (non-opioids), dry needling, etc (he went too fast!). In other states: Oregon has approved 30 visits per year and is favored (as well as CBT, PT, OT) over pain meds and surgery. Virginia just approved something similar.
    c) Naprapathy: Think massage therapist at the doctoral level. Treatment that focuses on connective tissue. Hands on, full body, nutritional counseling, therapeutic and stretching exercises. Plantar fasciitis, low back pain not due to bone disease. Stress. Myofascial release. NM and IL are the only states with licensed Naprapaths. There's a school in SF, NM has about 30 naprapaths in the state.
7) Medical Cannabis for Chronic Pain Presentation:
    a) Purpose: issues cards, licenses, monitory the safety of the medication. The Medical Cannabis Advisory Board meets twice per year and makes recommendations about new qualifying conditions.

b) List of qualifying conditions. There are 21 total.
c) Qualified patient must be a resident of NM and dx with a debilitating approved medical conditions.
d) Cards must be renewed yearly, the program gets up to 800 applications daily! 2017 there were 46k patients enrolled. Currently, there are 53k enrolled in the program. Of the enrolled, 20k patients are dx with chronic pain.
e) Medical background and science:
    i) Endo cannabinoid system, which regulates multiple body systems, CB1 and CB2 receptors throughout the body but not in brainstem (therefore, risk of overdose is lowered). THC can be intoxicating but CBD is not.
    ii) Evidence: One meta-analysis preclinical study showed that opioids and cannabinoids work together when co-administered. NM study showed that the patients enrolled in the program has a lower rate of opioid use. There is substantial evidence that pts with chemo induced nausea and vomiting improve with cannabinoid. As well as chronic pain. More research is needed.

8) Update on alternative pain committee
    a) Harris Silver, MD thinks "Alternative therapy" should be changed to "Integrative Pain Management" committee because "alternative" has the appearance of being second-rate when in fact, it is often first like treatment. This committee makes recommendations on how integrative pain can be inserted in the treatment modality for chronic pain.
    b) Risk of continued opioid use increases at the 4-5 day mark (CDC).
    c) Morphine equivalent daily dose is directly correlated with overdose death. One study found even at the 20 MME daily but multiple studies found the risk is greatest for those rx >100MME daily. Other risks include having a rx for buprenorphine, fentanyl, methadone, oxycodone, hydromorphone.
9) Update on benzodiazepines prescribing committee: is working with all the professional boards now. They will get together and make recommendations on safe BZD prescribing practices to the advisory council. (the new ED for the BON sits on this subcommittee).
10) Discussion topic: Narcan dispensing through hospital ED visit: Many ED's have become quite risk adverse but intranasal Narcan isn't even on many hospital formularies. Perhaps protocols, education, etc may help? The DOP has been working with many hospitals in NM to get the intranasal Narcan on the formulary (just got put on Presbyterian in Espanola approved!).
11) Next meeting: Friday August 24th 1:30.