

Opioid Prescribing Work Group

Minutes — August 17, 2017

noon – 3:00 p.m.

444 Lafayette Building, St. Paul

Members present: Julie Cunningham (remotely), Chris Eaton, Tiffany Elton, Dana Farley (non-voting), Brad Johnson, Chris Johnson, Ernest Lampe, , Matthew Lewis, Pete Marshall, Murray McAllister, Richard Nadeau, Charlie Reznikoff (remotely), Jeff Schiff (non-voting), Charles Strack

Members absent: Rebekah Forrest, Ifeyinwa Nneka Igwe, Lindsey Thomas

DHS employees: Titi Adeniyi, Dave Hoang, Tara Holt, David Kelly, Sterling Kowalski, Monica Patrin

Guests: Jim Cook (Mercer), Juliana Milhofer (MMA), Kelly Rousseau (WS), Mike Starnes (MPP), Amy Tran (DHS Pharmacy Student Intern), Kelley Waara-Wolleat (Purdue), Lisa Wichterman (DLI)

Welcome and Introductions

Chris Johnson called the meeting to order. Johnson welcomed members and guests, and introductions were made around the room.

DHS Updates

Jeff Schiff updated the work group on two recent opioid-related efforts within state government. First, Schiff and colleagues from the DHS Alcohol and Drug Abuse Division attended the State Targeted Response to the Opioid Crisis (STR) meeting in Baltimore in early August. As a result of the meeting, the Minnesota team identified the need for better integration of opioid-related efforts across the state. The Minnesota STR grant recipients will be announced in September via a press release. A large proportion of the grants are directed towards treatment and treatment supports, including grants to support expansion of office based opioid therapy (OBOT). Second, Minnesota government officials and staff have met over the past two weeks to discuss an opioid-related public health emergency – both at the state and federal level. Red Lake Nation declared a public health emergency in July, and the report out of the Trump administration’s opioid crisis task force recommended declaring a national public health emergency.

Charles Strack announced that Morrison County jail finalized approval to provide medication assisted treatment. The first recipient will receive Suboxone in the county jail. A waived physician in the community is providing treatment.

Approval of Minutes

Members unanimously approved the July meeting minutes.

Opportunity for Public Comment

No public comments were offered. Rinn reviewed meeting logistics. A copy of the presentation is available by request to dhs.opioid@state.mn.us.

Index Opioid Prescription Measure Discussion

Rinn reviewed the definitions commonly used in the opioid prescribing data analysis and proposed measures. She then provided a general overview of the two handouts used to support the meeting discussion: 1) The OPWG Opioid Prescribing Sentinel Measures discussion guide; and 2) the August 17, 2017 OPWG data handout.

Members reviewed the first measure: the percent of enrollees who were previously opioid naïve and received an index opioid prescription during the measurement year. The proposed measure is intended to provide a general picture of the patient population receiving an index opioid prescription. There is no threshold associated with this measure. A member asked whether an enrollee must be continuously enrolled in the MHCP and have an index opioid prescription to be included. Rinn clarified that the current analysis considers continuous enrollment only during the 90 day look back period. This measure includes enrollees who churn on and off the MHCP programs.

Members then reviewed the second measure: the prescribing rate of index opioid prescriptions that exceed the recommended dose of 100 MME or 200 MME. DHS staff clarified that the analysis for this measure will be completed for the September OPWG meeting. Members discussed the proposed threshold for this measure: a provider will exceed the threshold if 30% of index opioid prescriptions written exceed the recommended dose (100 MME or 200 MME, depending on specialty). Members were asked to wait to reach consensus until the support data analysis is completed. A brief discussion ensued about the OPIP quality improvement requirements for providers who exceed prescribing thresholds. Members asked how the process will work, in general terms. Schiff commented that the legislation does not provide DHS with authority to perform chart reviews or clinic visits, so DHS will rely on attestation of the provider to complete the agreed upon activities, and monitor the provider's prescribing data. The third measure discussed was the index opioid prescription morphine milligram equivalence prescribing rate. Members reviewed the data analysis completed for this measure for a limited number of specialty groups.

Discussion ensued about the ease of understanding the proposed measures. Members indicated that the first measure (frequency) is easily understood, but questioned the ease of understanding the third measure (composite measure of frequency and amount). Members debated whether it is more useful to report the two relevant measures—frequency and amount—separately, or to combine them into the composite measure. It is important that the measure assist the provider with identifying the practice change needed when prescribing behavior is outside of the community-accepted standard.

Discussion then turned to the significant variation between quartiles within specialty groups, demonstrated in the data analysis. Members discussed the natural variation that occurs within practice groups and specialties. One member voiced concern that the median MME per prescription is not a very meaningful number, because it does not take into account the variation in procedures and disease stated treated within a specialty group. DHS staff reminded members that it is difficult to tie procedure or diagnosis codes to opioid prescriptions at this scale. A brief discussion ensued about the need to

accommodate special cause variations for providers who practice is defined in some way by very intensive surgeries, or major trauma. Members expressed concern about recommending a measure that does not consider variation in practice types, and is not based on empirical evidence. Members expressed concern about whether measure three and the proposed threshold have quality improvement value, as defined.

Members discussed which of the three measures should be used in the prescriber reports and quality improvement process. A consensus was reached to include the first two measures in the prescriber reports: 1) the frequency of prescribing an index opioid prescriptions; and 2) the prescribing rate of index opioid prescriptions that exceed the recommended dose (100 MME or 200 MME). The composite measure—the index opioid prescription MME prescribing rate—should be in determining which providers require a performance improvement review.

Post-Acute Pain Prescribing Measure Discussion

Members reviewed the first of the post-acute pain prescribing interval measures: the rate of prescribing ≥ 700 MME cumulative MME to enrollees who received at least an index opioid prescription. Members reviewed the preliminary data analysis completed to support the measure. The data presented provided the percent of enrollees receiving an opioid prescription in the post-acute pain prescribing time interval (+ index opioid prescription) exceeding cumulative MME benchmarks. Benchmarks selected for the analysis included: 300 MME, 700 MME and 1,500 MME. Members reviewed the data and discussed the similarity in the rate of attrition among the specialty groups included in the analysis. The one exception was the general surgery category.

Discussion turned to consideration of the second measure in the post-acute pain prescribing interval: rate of MME prescriber per total number of distinct enrollees seen in the measurement year. Members reviewed the data in Table 13. Post-Acute Pain Prescribing Data: Family Medicine as an example. A brief discussion ensued about the relationship between providers placed in the highest quartile in the post-acute pain prescribing measures and those in the highest quartile for index opioid prescriptions. DHS staff commented that a brief analysis of this relationship was completed, and the data suggests that 75-80% of providers in the highest quartile for index opioid prescriptions remain in the highest quartile in the post-acute pain prescribing analysis. Members discussed the value of plotting prescribing rate geographically. Although DHS is unable to do so, Medicare has plotted opioid prescribing rates geographically and that analysis is available online.

Discussion returned to the use of 700 MME as benchmark for the post-acute pain prescribing measure. A member commented that the opioid prescribing guidelines currently do not include a recommendation about 700 cumulative MME exposure. The group recommended adding the 700 MME recommended limit into either the recommendations or the post-acute pain prescribing and assessment guide.

DHS staff will complete additional analysis for the September OPWG meeting, based on the discussion during the meeting. The work group then briefly discussed the provider reports and reporting mechanism. Members expressed interest in reviewing a mock report at the next meeting, so DHS staff will prepare a draft report to review. Discussion then turned to the reporting mechanism. DHS staff commented on the preliminary discussions underway, and the desire to automate the process the greatest extent possible while honoring the peer protected review status of the report. A member

voiced support for the report coming directly from DHS, rather than go through a clinic manager, etc. Members briefly discussed the process for review, the responsibility of providers to check their reports, and the consequences of failing to check report or comply with the provider quality performance review.

Meeting adjourned.