

## Opioid Prescribing Work Group

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Minutes — November 21, 2019

noon – 3:00 pm

444 Lafayette Building, St. Paul

**Members present:** Julie Cunningham, Sen. Chris Eaton, Tiffany Elton, Dana Farley, Rebekah Forrest, Chad Hope, Ifeyinwa Igwe (remotely), Brad Johnson, Chris Johnson, Ernest Lampe, Murray McAllister, Pete Marshall, Richard Nadeau, Charlie Reznikoff (remotely), Charles Strack, Lindsey Thomas

**Members absent:** Matthew Lewis

**DHS employees:** Ellie Garrett, Jessica Hultgren, David Kelly, Sarah Rinn

**Guests:** Malia Cole (patient advocate), Jodie Dvorkin (ICSI), Audrey Hansen (ICSI), Rahul Koranne (MHA), Trudy Ujdur (Sanford), Ann Tart (DLI)

### Welcome and Introductions

Chris Johnson welcomed members and introductions were made around the room.

### DHS updates

Ellie Garrett provided a brief update on recent agency activities. DHS Commissioner Harpstead will complete her first 90 days at the end of November. She is expected to announce appointments to open leadership positions. Garrett also shared that the agency received an additional amount of funding under the State Opioid Response grant. Part of the additional funding is to support statewide quality improvement for opioid prescribing and access to opioid use disorder treatment.

### Approval of minutes

Lindsey Thomas moved to approve the October OPWG meeting minutes, with one edit. The word “are” should be added to the second sentence of the second full paragraph on page. The modified minutes were approved unanimously.

Sarah Rinn provided three OPIP updates. First, Commissioner Harpstead approved a two-year extension of the OPWG. Rinn will share application instructions with the work group members once the vacancies are posted on the Secretary of State’s web site. Second, DHS leadership asked OPIP staff to identify an alternate distribution method for the 2019 updated opioid prescribing reports. OPIP staff expect this will cause a minor delay in sending out the reports, but the goal is to send them out by the end of the year. Third, DHS created a new email list serv—OPIP GovDelivery—to communicate about the opioid prescribing reports and quality improvement program. People interested in receiving updates can sign up on the OPIP web site. OPIP staff will continue to send out updates on the OPWG distribution lists.

## **Opportunity for public comment**

There were no in-person public comments offered. Rinn informed work group members that an email exchange between Charlie Reznikoff and Katie Nixdorf is in the meeting folder for their review. Katie Nixdorf is an internal medicine doctor at Fairview and the CMO of their pain clinic. The email exchange is about concerns related to the prescriber reports, and clarification around the intended goal of the project.

## **2019 HHS taper guidance**

Members reviewed the recently published federal Department of Health and Human Services Opioid Taper Guidance. The guidance was released in October 2019. Rinn shared a brief review of the taper guidance in the Minnesota Opioid Prescribing Guidelines and the 2016 CDC guidance. She then provided a brief overview of key points in the new HHS taper guidance. Work group members were asked to weigh in on whether the OPWG would like to revise the MN recommendations in light of the new federal guidance. This could include either a revision to the MN recommendations or an addendum of the federal guidance.

Members discussed the strengths of the new guidance, including the emphasis on very slow tapers for patients who are not at risk of imminent harm. Using a slower taper—5-20% every 4 weeks—is now generally recognized as an appropriate starting point. The new guidance also emphasizes the individualized nature of tapering or discontinuing opioid therapy. A member commented that the MN guidance recommends doing the taper in conjunction with a behavioral health provider, but that this strategy is dependent on access to those providers and may not be feasible for everyone. Discussion turned to whether slowing down tapers is more burdensome for providers, given that patients will likely need more touch points during the taper process. Members who taper patients frequently as part of their practice indicated that check-ins during a taper do not always have to be face-to-face. Many providers leverage nursing support to make follow-up calls. The general consensus of the work group was that members are open to modifying the taper guidance. DHS staff requested that the work group wait to make any modifications until after DHS holds the chronic pain patient meeting.

## **Chronic pain patient meeting**

Garrett provided an overview of the chronic pain patient community meeting scheduled for December 2. The primary purpose of the meeting is to hear from chronic pain patients about their lived experiences receiving long-term opioid therapy. DHS staff will also use the opportunity to address misinformation shared about the program, and level set around the goals of the project. A member asked if DHS staff are developing specific questions for the patient community to address, and staff confirmed that is in process. Discussion briefly turned to acknowledging patients' rights while receiving care. A member expressed concern about whether patients understand how to have their concerns addressed or register complaints at the clinical level. Both DHS and MDH field a lot of calls and concerns about challenges obtaining treatment, but there is little that either entity can do at the clinic level. Members in the room who care for chronic pain patients commented that there is often a lot of dissatisfaction on the patient's behalf due to the very limited time available during office visits.

## Health system meeting

Rinn provided a brief overview of the health system meeting scheduled for November 22. The meeting is co-convened with the Minnesota Hospital Association, and ICSI and MMA staff will also attend. Dr. Rahul Koranne, MHA Chief Medical Officer, and Dr. Jodie Dvorkin, ICSI Chief Medical Officer, joined the work group members for a brief discussion about the meeting. Rinn provided an overview of the agenda for the meeting. The two main agenda items are to discuss the distribution method for the opioid prescribing reports and gather input on a more effective process, and to have an initial discussion about the quality improvement program.

A member commented that the opioid prescribing reports are a powerful tool, and he is concerned that the distribution of the reports has been unsuccessful. Other members echoed concerns that providers are not receiving the reports, and that there is generally a lot of frustration using the DHS MN—ITS mailboxes. In addition, there is a lot of concern about fixing the specialty designation of Physician Assistants and Advance Practice Nurses.

Koranne provided a brief overview of who is expected at the health system meeting. MHA reached out to systems across the state, and expects approximately 60 people in attendance (both in person and on the phone). Audrey Hansen (ICSI) relayed concerns that she hears about providers' confusion around which prescribing guideline they should follow, and commented on the challenge faced by systems to comply with all of the varied guidance. ICSI, DHS and MHA staff all agreed that the organizations must partner to create consistency.

Discussion then turned to how DHS needs to support the systems. The health care systems want to understand how to support their providers, and how to work with the state regarding providers who have very high prescribing rates. There is also a strong desire to understand how to replicate the DHS methodology for the sentinel measures. Another member commented on the growing patient population receiving long-term opioid therapy in their clinic, and how that will influence the reports for their providers. There are also a lot of patients coming into surgery or cancer settings who are already highly tolerant. Discussion then briefly turned to the need for better education and resources around calculating MME. Providers need a standardized, readily accessible way of calculating MME in the post-surgical setting. Member briefly commented on the varying states of EHR compatibility across systems.

A member expressed concern about the consequences of failing to comply with the quality improvement program. Disenrollment from the Minnesota Health Care Programs will have very serious consequences for providers, and for health plans who serve MHCP members. DHS staff reminded members that the disenrollment criteria will be different from the QI criteria, and that the work group will work on disenrollment in 2020. There appears to be a lot of confusion about the QI thresholds for the program. For example, one of the misconceptions is that the QI thresholds equate to the rank within a provider's specialty group. In other words, a measure with a QI threshold of 10% is being interpreted to mean that the provider is within the top decile among his or her specialty peers.

A brief discussion ensued about the need for payers and health systems to increase access to non-opioid and non-pharmacological treatment options. Members representing payers and those who work within integrated clinics commented on coverage and use of alternative therapies within their systems.

## **Chronic pain provider reports: Concern about thresholds**

Rinn presented a de-identified opioid prescriber report in order to illustrate a concern voiced by the chronic pain provider community. The provider is a nurse practitioner in a pain clinic. The provider's data for measures four through seven were consistent with what is expected for providers who manage chronic pain. However, the provider in question also had prescribing rates above the QI threshold for measures in the acute pain phase. It is possible that the report captures previously-naïve opioid naïve patients with chronic pain who initiate opioid therapy. Therefore, it could be misleading to label this measure as data related to "acute pain". Members were asked to consider whether the terminology used for measures 1 through 3 on the provider reports should be changed from "acute pain" and "post-acute pain" to initiating opioid therapy. Members reached consensus to leave the labels as is, given that most of the patients and prescriptions captured in measures 1 through 3 are likely receiving opioid therapy related to acute pain (an acute event).

Rinn briefly reviewed changes suggested for the quality improvement attestation forms. Work group members will review the activities during the December meeting.

## **Quality Improvement program volume thresholds**

Jessica Hultgren reviewed the current volume thresholds that a provider has to meet in order to qualify for the quality improvement program. The volume thresholds are applied in addition to the quality improvement thresholds. The current volume thresholds for measures five and six are  $\geq 5$  patients in the denominator. This means that the provider prescribed opioids to at least 5 patients with a COAT span in the measurement period. Hultgren asked that the work group members revisit the volume threshold, due to concerns that the current threshold permits providers with as few as 2 patients meet the QI threshold. DHS received feedback following the initial round of reports that requiring QI from providers who very infrequently prescribe is not reasonable. DHS staff agree, and re-analyzed the data using different volume thresholds.

Hultgren presented the analysis of using a threshold of 10 patients in the denominator for measures 5 and 6, as well as using a threshold of 5 and 10 patients in the numerator for the same measure. She reviewed the average rate, range and number of providers flagged for QI using the current threshold and the three alternates. Members reviewed and discussed the data, and ultimately reached consensus that using a numerator of 5 or more for measures 5 and 6 adequately captures a sufficient number of providers who appear to prescribe COAT on a frequent basis. Changing the volume threshold also significantly reduces the number of providers flagged for QI who have 2-3 COAT patients. Chris Johnson called for a vote. The change was approved unanimously.

Meeting adjourned.