Opioid Prescribing Work Group

Minutes — September 24, 2020
12:00 pm – 3:00 pm
WebEx Video Event

Members present: Nathan Chomilo, Kurtis Couch, Julie Cunningham, Kurt DeVine, Sen. Chris Eaton, Dana Farley, Tiffany Elton, Rebekah Forrest, Brad Johnson, Chris Johnson, Ernest Lampe, Matthew Lewis, Murray McAllister, Richard Nadeau, Adam Nelson, Charlie Reznikoff, Saudade SammuelSon, Lindsey Thomas

Members absent: Chad Hope, Adam Nelson, Charles Strack

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

Guests: Amber Bullington, Charisse Colombe (MHA), Sheila Grabosky, Audrey Hansen (ICSI), Renee Hazelbaker, Cammie LaValle, Tracy Radtke (MHA), Ann Tart (DLI), Lisa Wichterman (DLI)

Welcome and introductions

Julie Cunningham called the meeting to order and welcomed members. OPWG members and DHS staff introduced themselves. DHS staff announced that Kurt DeVine, MD, was appointed by DHS Commissioner Harpstead to the licensed physician seat. DeVine is a rural family medicine and addiction medicine provider at CHI St. Gabriel's in Little Falls. His work on opioid prescribing over the past several years includes implementing a Controlled Substance Care Team program in his clinic to improve care for patients in chronic pain or who experience opioid use disorder, establishing medication assisted treatment (MAT) protocols in the Morrison county jail, and co-facilitating weekly ECHO clinics on controlled substance prescribing for several different audiences, in addition to his clinical practice.

Approval of minutes

Cunningham called for a motion to approve the June minutes. Richard Nadeau moved to approve. The minutes were approved unanimously.

DHS updates

Nathan Chomilo provided an update on DHS' anti-racism work. He commented that addressing race and equity within DHS programs is what brought him to this work. DHS recently created a strategic leadership group to examine how DHS policies and practices can be more actively anti-racist. This work is intended to address issues that existed prior to this summer. Chomilo commented that this work may end up touching the Opioid Prescribing Improvement Program (OPIP).

Ellie Garrett announced that Minnesota received $22 million ($11 million annually for 2 years) in new federal funding. The State Opioid Response (SOR) grants are administered by the Substance Abuse and Mental Health Agency (SAMHSA). A portion of the funds are specifically dedicated to efforts or named organizations, but

another portion will be awarded via a competitive grant process. Priorities for this round of funding include addressing disparities among American Indian and African American communities. A portion of funds will be allocated for a contractor to provide technical support for the OPIP quality improvement program. DHS is also preparing for the next legislative session.

Opportunity for public comment

Two items were submitted for review with the meeting materials:

- A letter from the National Council on Independent Living. The letter provided specific comments and concerns about the clinical guidance for COAT within the 2018 Minnesota Opioid Prescribing Guidelines.
- An article by Red Lawhern, PhD from the Facial Pain Advocacy Alliance: "Figures Lie and Liars Figure – Why the demographics of the so-call 'prescription opioid crisis' don't work." The article was submitted by Amber Bullington.

Jessica Hultgren read an email to the group from Cammie LaValle. Ms. LaValle provided comment on the draft taper guidance. Her concerns include:

- The 90 MME daily dose limit used in the quality improvement program contradicts the language in the taper guidance draft. If tapering is not done to meet a specific dose or MME, then why are there still thresholds in the QI program?
- When will details about special cause exemption be made available? Including, who approves the requests, are their patients exempt from taper? Palliative care and intractable pain patients are getting tapered. Will they be held accountable for tapering opioid therapy in palliative care patients?

A member responded to the public comment provided about the risk and benefit of chronic opioid analgesic therapy. He commented that the evidence to support the efficacy of long-term opioid therapy is not there. The SPACE trial – the best scientific study completed to date – did not demonstrate benefit. Another member commented that this must be weighed against the statements and experiences of chronic pain patients. For some people who receive chronic opioid analgesia, opioids may remain the best option available.

A member commented on the safety aspect of tapers. When providers began prescribing opioids for chronic pain in the late 90s, often times other non-opioid options were not attempted first. Now the medical community has to correct that approach.

Quality Improvement (QI) presentations

Hultgren presented the proposed quality improvement program plan for 2021. A copy of her presentation is available upon request. A brief discussion ensued based on the proposal to exclude measure 3 (post-acute pain) from the quality improvement program in year one. A member asked whether there is evidence that the risk of a patient becoming a COAT patient is higher when their acute pain prescription is too high, or is it higher if their post-acute pain prescriptions is too high. She expressed concern about eliminating individuals who are over the measure 3 threshold. Another member commented that the risk is continuous and dose dependent over time, but the evidence to support this is based on retrospective data so it should be taken with a grain of

salt. Members expressed some concern about not focusing on post-acute pain at the beginning, given that it is a cornerstone of the OPIP work. Members then discussed the challenges with measuring opioid exposure in the post-acute timeframe in electronic health records (EHRs). A DHS staff member reminded members that the proposal is just for year one, and that there will be an opportunity to require QI around post-acute pain care in subsequent years. Consensus emerged that not requiring QI based on measure 3 is an acceptable compromise to start with a more measured QI program in 2021.

Members briefly discussed the proposal to include PMP use in the attestation form. Members briefly discussed the recommended frequency of PMP queries in the prescribing guidance, and whether health systems have successfully incorporated PMP queries into their EHRs.

A member commented on the opportunity to work with payers on the project. He briefly explained the work done at South Country Health Alliance around new chronic use and interventions to improve prescribing in the post-acute pain phase.

Discussion then turned to the quality improvement proposal for chronic opioid analgesic therapy (COAT) prescribers. Hultgren reviewed the proposal to convene a group of providers who prescribe COAT to develop consensus around quality improvement efforts. Garrett commented that this would be somewhat akin to the focused work done on post-surgical prescribing. A member commented that we will have to define carefully what is meant by pain specialists. Is it a fellowship trained specialist, or a nurse practitioner who handles prescribing at a clinic? Another member commented on the importance of including primary care providers, especially because rural patients cannot readily be referred to a specialized pain clinic to handle opioid management. A member acknowledged that there is variation in individual needs for opioids, and variation among pain specialists. However, we cannot lose sight of the fundamental response of the brain to opioid exposure and the dose-response relationship to opioid-related harm.

Members discussed at length their concerns about the proposed decision criteria to require continued QI in year two, or “graduate” the provider from the QI program. Several members agreed that the proposal will act as an incentive to discharge COAT patients from care, and a disincentive to take on chronic pain patients. DHS staff clarified that continued QI does not necessarily mean more required QI activities. Members acknowledged this, but expressed concern that providers will just seek ways to get out of the QI program. A member commented that in his own clinic, conversations about dosing for chronic pain patients have resulted in the provider dumping the patient on another provider in the clinic. Several members commented in the chat that these are exactly the concerns expressed by chronic pain patients during our public comment periods. Members began to discuss ways in which the state can monitor prescribing behavior during the QI period. In addition, it is very important that DHS is able to link the narrative told in the attestation form to the data. In the chat function, a member asked what happens when providers are over a quality improvement threshold in one measure during year one, and then over a different measure in year two. Another member commented that it may need to be a priority to engage additional pain medicine providers to better understand the QI challenges.

Several chronic pain patients commented in the chat that many of the concerns expressed by members during the conversation reflect the current experience of patients.

After the break, the chair proposed separating the conversation about the acute and chronic pain quality improvement, and develop consensus around the acute pain approach first. A member commented that he

does not have concerns about the acute pain QI approach, but does have concerns about how the program and expectations are communicated to providers. Many providers do not understand the OPIP sentinel measures, and need a better understanding before they embark on QI. In addition, patients do not understand that providers are making decisions based on overall dose. Often the patients end up with only a 1-2 day prescription, and then are required to obtain additional prescriptions and pay additional co-pays.

A member observed that he is not certain there is a difference between the acute and chronic pain QI program, given that both could have unintended consequences. Practice change is always a struggle, and there are always unintended consequences to actions. We need to provide guidance around how to balance that, likely by developing guardrails against bad practice for all of the measures. A member agreed that is a fair assessment, but the chronic pain population has higher rates of comorbidities with substance use and mental health disorders. This is a very vulnerable population. Patients with acute pain are generally less vulnerable.

The discussion turned to the underlying challenge with changing practice around opioid therapy – the stigma around opioid use, chronic pain, dependency, and use disorders. A member commented that health care is replete with practice changes based on evidence that finds the practice is not beneficial. As a result of increased evidence, practices change. This is part of routine continuous improvement. However, opioid therapy is different due to the stigma associated with opioid use. A member commented that one of the other realities of prescribing opioid analgesia for chronic pain is that it has become very complicated for providers. Clinic visits have increasing requirements, which all have to be documented, and some providers view this as a hassle. Rather than adding requirements to site visits, the focus should be on educating providers about good practice.

Garrett commented that the approach to QI within a practice and the approach at the state agency level is very different. The scale of the project requires us to do some things differently than how this would occur within a practice. In addition, we are required to do QI in the OPIP statute and there are certain activities that are required.

The discussion turned to the consequences of disenrollment from the Minnesota Health Care Programs. For some providers, this will have a significant impact on their career. Therefore, this process must be very simple and understandable. In addition, DHS needs a less threatening stick than disenrollment. Lampe agreed and shared that the Department of Labor and Industry (DLI) is concerned about the under treatment of pain among workers compensation recipients. Often, providers do not know a patient is covered by workers compensation until after they receive treatment.

A brief conversation ensued about the need to honor COAT patients' goals. A member commented that if a patient is able to maintain the lifestyle he or she desires on long-term opioid therapy that needs to be considered in any decision to change therapy. Insurance does not pay for many non-opioid treatments, so some patients have to rely on opioid therapy for pain management. Discussion ensued about weighing the existing evidence base about long term opioid therapy for chronic pain and the current experience of chronic patients.

The conversation about QI concluded with a discussion about improved metrics. One member commented that the QI program requires better metrics for success. Another member agreed that while we need more nuanced metrics, we also have an obligation to see this program to its completion. And more importantly, there are still people developing opioid use disorder and experiencing other adverse effects.

A brief discussion followed about the adverse consequences of both opioid analgesic therapy and the effect of patient abandonment and discontinuation.

Taper guidance revision

Rinn provided a high-level overview of the changes to the taper guidance. The work group agreed to review the changes and send a final round of comments back by October 8.

Meeting adjourned.