Opioid Prescribing Work Group

Minutes — August 26, 2021
12:00 pm –2:00 pm
WebEx Video Event

Members present: Emily Bannister, Kurtis Couch, Julie Cunningham, Kurt DeVine, Chris Eaton, Dana Farley, Bret Haake, Chris Johnson, Matthew Lewis, Murray McAllister, Richard Nadeau, Adam Nelson, Charlie Reznikoff, Saudade SammuelSon, Lindsey Thomas

Members absent: Nathan Chomilo, Tiffany Elton, Rebekah Forrest, Chad Hope, Charles Strack

DHS employees: Ellie Garrett, Renee Hazelbaker, Jessica Hultgren, Melanie LaBrie, Sarah Rinn

ICSI staff: Jodi Dvorkin, Audrey Hansen

Welcome and introductions

Julie Cunningham called the meeting to order and welcomed members. Opioid Prescribing Work Group (OPWG) members introduced themselves. Sarah Rinn shared that the May meeting minutes will be distributed in advance of the September meeting. The work group welcomed Emily Bannister, MD, to the group. Dr. Bannister is the new medical consultant at the Minnesota Department of Labor and Industry.

State agency updates

Ellie Garrett briefly reviewed the updates to the OPIP legislation that passed in July. First, the two consumer members who experience chronic pain are now voting members. Second, DHS now has the appropriate authority to distribute all future opioid prescribing reports directly to health systems.

Opportunity for public comment

Sheila Grabosky provided public comment, and disclosed no financial conflicts of interest. She shared her concern that there was a proposal to remove the following statement from the guidance: *Providers should not taper a patient for their own convenience or solely to comply with a pharmacy benefit manager, health insurance company, health system or state policy.* She shared how she is personally affected by coverage limits on non-opioid pain treatment modalities, namely that it results in needing a higher daily MME to manage her pain and maintain function. Ms. Grabosky expressed disappointment that the language was removed from the guidance.

Note: The statement that Ms. Grabosky referred to in the taper guidance was reinstated and approved by the OPWG members.

Overview of the 2021 quality improvement program

Sarah Rinn presented a status update on the 2021 quality improvement program. A copy of the slide presentation is available upon request. She reviewed the resources that have been developed to support participants, as well as the documentation that prescribers must complete and return to DHS by the end of November 2021. A member asked about the response rate to the request, and Jessica Hultgren informed the group that there is about a 50% response rate to date. Twenty four prescribers have requested a clinical review of their special cause request. Members briefly discussed their concerns that clinicians are confused about the meaning of the reports and the quality improvement program, and are reacting incorrectly. A recommendation was made that DHS contact the QI liaisons and ask that they check in on their participating clinicians. DHS confirmed that it will do so within the next few weeks.

Successes in year one launch

Rinn presented an overview of what is going well in year one, and Audrey Hansen (ICSI) provided additional detail. Successes include a high level of engagement with liaisons at some health systems, productive conversations with either individual clinicians or groups about the types of systems barriers that impact their prescribing, and an increase in awareness of the resources available to clinicians and systems to support quality improvement.

Jodi Dvorkin, MD (ICSI) presented a brief update on the chronic pain work. She reviewed the structure and design of the work. Using human centered design principles to guide the work, ICSI convened two cohorts: one made up of patients who use opioid therapy to manage their chronic pain; and one made up of clinicians who treat patients with chronic pain. The intended outcome of the work is a set of principles of care for patients with chronic pain. Themes emerging from the prescriber group include the importance of organizational support, education, and insurance coverage issues. Themes emerging from the community cohort include the importance of a trusting relationship, frustrations with not being heard, and a general sense of hopelessness.

A brief discussion ensued about the chronic pain work. Dvorkin confirmed that there is overlap between the OPWG and the steering committees for the ICSI work. A member shared two concerns related to this work. One, the understanding that getting off of opioid therapy can lead to decreased pain can be difficult to process, especially for patients who are in this cycle of despair or who believe they need opioids to function. Two, not all clinicians who treat pain are good at treating pain. It should be the role of the steering committee to determine how much this dynamic is present in the work, and whether it is affecting the outcome. ICSI staff acknowledged they are mindful of this dynamic. A brief discussion ensued about the additional challenge of addressing opioids for pain management and pain management in general, and the role of mental health support in defining principles of chronic pain care.

A member shared her experience of tapering off of opioid therapy, and that a turning point in her pain management journey started when she found a physician with whom she was able to build a relationship. At the point when their therapeutic relationship was strong enough, he introduced the concept of removing opioids from her pain management regimen. He took time to explain why she should taper, and supported it with data and information. But the key to the success was that he told her they would try to taper, and if it did not work after a designated amount of time, they would revisit the opioids. She shared that because she trusted him, she attempted the taper and it was successful. It changed her experience of pain. When she

began a new pain management regimen and started to change how she thought about the pain, her own system's ability kicked in. She shared that she believes it saved her life. The key to this was that she had enough time to build a trusting relationship with her physician, and she did not fear that he was just trying to trick her into stopping opioid therapy.

Learning opportunities for next QI program cycle

Rinn presented an overview of some of the challenges arising in the first year, including identifying where clinicians practice, a broad spectrum of readiness to engage in quality improvement, a broad spectrum in knowledge around current opioid prescribing community standards, and the special cause request process and expectations.

A brief discussion ensued about some of the issues arising in the special cause request process. First, DHS and OPWG members shared their concern about the high number of pain medicine providers who are over the QI threshold for prescribing to an opioid naïve individual. In addition, DHS and ICSI staff shared that the special cause requests do not address this aspect of their prescribing. Members expressed concern about the lack of knowledge and support for using MME as the dosing standard (instead of days of number of pills). Members then discussed the current dynamic of referrals from primary care to pain medicine clinics. A member expressed that having a large patient panel with high daily dosage due to referrals is a valid issue, but the pain medicine providers need to engage in some kind of reduction strategy over time. Hansen shared that this tension between primary care and pain medicine has come up during the human centered design work, and the tension is felt by both parties. However, the important thing is that the patient is getting caught in the middle, and experiencing these disruptions in care.

In response to this discussion, a member postulated that we may be mature enough as a community to discuss what a model pathway could be for patients in this situation. One possible solution is to involve addiction medicine in the care of patients with chronic pain who are on a stable regimen of buprenorphine for pain management. At the point when the patient is ready to attempt a reduction, then mental health, physical therapy, physical medicine and others can be involved in supporting the patient. This model may not have been possible 5 years ago, but it seems like the community is getting closer to being able to support it. This work is ahead of the medical literature, but it is also the kind of creative work that could drive improvement.

Meeting adjourned.