Opioid Prescribing Work Group

Minutes — September 23, 2021
12:00 pm –3:00 pm
WebEx Video Event

Members present: Emily Bannister, Nathan Chomilo, Kurtis Couch, Kurt DeVine, Chris Eaton, Tiffany Elton, Dana Farley, Rebekah Forrest, Bret Haake, Chad Hope, Chris Johnson, Matthew Lewis, Murray McAllister, Richard Nadeau, Charlie Reznikoff, Saudade SammuelSon

Members absent: Julie Cunningham, Adam Nelson, Charles Strack, Lindsey Thomas

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

ICSI staff: Audrey Hansen

Welcome and introductions

Ellie Garrett called the meeting to order and welcomed members. Opioid Prescribing Work Group (OPWG) members introduced themselves. Members reviewed the June and August OPWG meeting minutes. Both the June and August meeting minutes were approved unanimously.

State agency updates

Garrett briefly shared two updates. First, the Minnesota Hospital Association (MHA) produced a series of opioid analgesia roadmaps for organizations and prescribers, with support from DHS. The organization-level roadmap addresses opioid stewardship, and MHA produced several resource documents to accompany the materials. The road maps are available on their web site.

Second, the governor's office is soliciting input on priorities for the American Rescue Plan Act (ARPA) funds through the end of September. The ARPA funds are intended to provide relief to those negatively impacted by COVID-19. An estimated $8.5 billion will be allocated to the State of Minnesota, and the legislature will consider how to allocate those funds during the next legislative session.

Opportunity for public comment

Cammie LaValle shared that she has no financial conflicts of interest to disclose. Ms. LaValle addressed two documents that were circulated prior to the meeting: 1) American Medical Association recommendations for updated CDC Guideline for Prescribing Opioids; and 2) Observations of the Opioid Workgroup of the Board of Scientific Counselors of the National Center for Injury Prevention and Control on the Updated CDC Guideline for Prescribing Opioids. She asked whether the OPWG has reviewed these recommendations, and what does the work group plan to do with this information. Specifically, is there a response to the opioid work group's recommendation on MME limits and its impact on patient care?

LaValle also asked whether there is going to be an expansion to the chronic pain project facilitated by ICSI under the DHS contract. She asked whether there are plans to address topics that have not been addressed to date. Garrett requested that she listen to the update provided at the end of the meeting, and then contact DHS with any follow-up questions.

Chronic opioid analgesic therapy (COAT) patient data review

Sarah Rinn presented data on enrollees receiving COAT in 2019. A copy of the slides is available upon request. Key findings the analysis include:

- Over 70% of enrollees receiving COAT had 200+ days with an active opioid prescription in 2019;
- 73% of enrollees receiving COAT had an average daily dose < 50 MME; enrollees receiving COAT > 90 MME was about 10%; and
- 60% of COAT enrollees had a comorbid mental health diagnosis in 2019; and 20% had both a mental health diagnosis and a substance use disorder diagnosis.

Members asked DHS about how the Medical Assistance and MinnesotaCare (Medicaid) population compares to the general population in Minnesota. DHS staff shared that just under 25% of the state is insured through Medicaid, which represents about 1.38 million people. Garrett clarified that the Medicaid population tends to be younger on average, given the enrollment criteria and the large number of children and pregnant women enrolled in the program. The population also generally has a higher prevalence of mental health conditions and substance use disorders; and the population has proportionately more people of color and Native Americans than the general population.

Discussion turned to the linear relationship of opioid dose and risk of harm. Although a high percentage of enrollees receiving COAT have daily doses under 50 MME/day, it does not mean they are risk free. A member requested that DHS circulate the 2015 research article that demonstrate the linear dose-risk relationship of opioid therapy. Members also discussed the high rates of mental health conditions and substance use disorder. The data reflects the national data and literature on the adverse selection phenomenon that occurs with opioid therapy and mental health conditions; patients with mental health conditions and a history of substance use disorder are more likely to receive opioid therapy than those without.

A question arose about whether it is possible to know which happened first: initiating opioid therapy or the mental health diagnosis. These are not independent phenomenon, and it may be useful to understand whether prescribers are analyzing the risk prior to prescribing, and how it changes after COAT is established. DHS staff clarified that this data analysis did not consider the sequence of the events, instead the data shows if either were present in the measurement period.

Disenrollment standards

Rinn reviewed how the OPIP will work with the DHS Office of Inspector General (OIG) Surveillance and Integrity Review Section (SIRS) to operationalize the OPIP disenrollment standards. The OPWG is tasked with developing clinical definitions of opioid prescribing behavior that could be subject to sanctions. The OIG-SIRS unit will use those definitions to investigate clinicians per their standard operative procedure. This includes a robust investigative process, and due process for the clinician investigated (if a case is opened). This information was a review of information previously shared with the OPWG by OPIP and OIG staff.

A member commented that there are some practices that warrant investigation, rather than individual providers. For example, a pain medicine physician who dictates prescribing standards to an advance practice provider (APP). If the physician is requiring a prescribing practice outside of the community standards, then the APP will continually be subject to QI requirements. There may be other instances when a medical department is under stress due to staffing changes, e.g., retirements, and the department as a whole decides it is not going to take on any of the opioid therapy. If it is an explicit policy, that is very concerning.

Data review for select domains

Rinn presented a data analysis related to two of the proposed disenrollment standard domains: abrupt opioid taper to discontinuation and continued prescribing after a life-threatening event or condition. A copy of her presentation is available upon request. The key take-away messages from the taper data analysis include:

- Among the enrollees who discontinued chronic opioid analgesic therapy in between 2016 and 2020, over half discontinued without a taper regimen (opioids abruptly discontinued).
- Approximately 80% of enrollees who tapered had a peak daily dose of < 50 MME/day
- Enrollees previously on doses < 50 MME/day were tapered very quickly off of their therapy.
- Enrollees previously on doses > 90 MME/day experienced a more equal distribution of slow and fast tapers.
- Enrollees previously on doses > 90 MME/day were more likely to experience an opioid-related adverse event which resulted in an Emergency Department (ED) visit or hospitalization.

DHS staff clarified that the opioid-related adverse events include opioid poisonings (non-fatal overdoses); opioid withdrawal and Opioid Use Disorder (OUD). Members briefly discussed that the data supports the anecdotal evidence provided by the pain community, and that many tapers fall outside the guidance.

Dana Farley asked whether this analysis could be separated by gender or race in order to better understand any related health disparities. He shared an additional perspective on the data, based on the recent report out of the Department of Health's (MDH) on nonfatal overdose data. MDH found that Emergency Department (ED) visits decreased over 2020 except for ED visits related to opioids. An ED visit is a good indicator for an adverse event, but the pandemic impacted how people used the ED. This insight may help avoid any unintended consequences to those who are experiencing health care disparities.

DHS staff shared that it seems unlikely that we will be able to develop a reliable taper measure at the prescriber level that could be included in future reports. However, the data shows that there is a real cause for concern around abrupt tapers.

Next, DHS staff presented a preliminary analysis of the frequency with which enrollees who experience an opioid-related adverse event receive an opioid analgesic within 30 days of the adverse event. The opioid-related adverse events were the same as those included in the taper data analysis: opioid poisonings, and opioid-related events such as withdrawal and OUD. The data shows that between 2016 and 2020, there were 84,118 adverse opioid events and in 20% of the events (n=16,943), there was an opioid analgesic prescribed within 30 days of the event. For 90% of the instances when an opioid analgesic was prescribed within 30 days, the opioid-related adverse event was not the primary diagnosis on the initial claim submitted to DHS. Data also shows that both the percent and absolute numbers of people receiving an opioid analgesic within 30 days of an adverse event is declining over time. The mean MME of the post-adverse event prescriptions in 2020 was approximately 600 MME; and the majority of the prescriptions were oxycodone and hydrocodone.

Members commented on the fact that current rate of patients receiving opioid analgesia after an opioid-related adverse event is significantly lower than the 90% rate found in past medical literature. Members briefly discussed the challenges associated with conveying information about non-fatal overdoses to primary care providers. Unless the prescriber is in the same system as the hospital where the patient was treated, it is very hard to know that a non-fatal overdose occurred. This may mean that a clinical standard has to address instances when a clinician continues to prescribe after an event they knew about, or should have known about.

Domains

Members reviewed the list of domains for consideration as disenrollment standards; the proposed domains include: 1) abrupt taper to discontinuation; 2) continued prescribing after a life-threatening event or condition; 3) contraindicated polypharmacy; 4) failure to screen for or appropriately treat opioid use disorder; 5) excessive dosing (> 500 MME/day), with additional criteria; and 6) complete failure to participate in the quality improvement (QI) program for 3 consecutive years.

There was general consensus that these domains are appropriate starting points. A member suggested that the standards somehow address systems of clinical practice, e.g., where more than one provider in a clinic is participating in the care of the patient, especially physician and advance practice provider partnerships. Several members indicated that the timeline for failure to participate in the QI program could be shortened to 2 years.

Discussion turned to the challenges associated with these domains. Prescribing after an adverse opioid-related event is sometimes warranted. A patient may need an opioid prescription between an adverse event and initiating treatment for OUD. In addition, people with treated OUD can and should receive opioid analgesia when appropriate. Members also briefly discussed the need to focus on high doses considering whether an abrupt taper is unsafe.

A member suggested adding prescribing opioid analgesia for non-indicated conditions to the list, specifically prescribing opioid therapy for a mental health diagnosis. It is not appropriate to prescribe opioid therapy for depression or personality disorders. There was general consensus among members to add failure to screen or appropriately respond to a serious mental health risk. This should be a separate domain from the failure to treat or appropriately respond to OUD. A member expressed concern about how rapid tapers may exacerbate anxiety disorders and other mental health conditions, so it is important to add this domain to the list.

Members briefly discussed other use disorders, and there was consensus to add other use disorders to the standard around screening for and responding to OUD. OUD and alcohol use disorder are the primary conditions to assess, but the domain can address use disorders in general.

Process for developing clinical definitions

DHS staff proposed a small group of volunteers from the OPWG work offline to help draft the clinical definitions for these standards. Then the entire group will discuss and vote on the standards during the October – December meetings. As a reminder, the task for the OPWG is to develop and recommend clinical definitions that DHS can incorporate into the OPIP statute or an administrative rule. Then the OIG will have the authority to investigate and potentially sanction clinicians based on these practices. The OIG team will

determine whether investigations are warranted, the scope of the problem (including patient outcomes), and the appropriate sanctions.

Discussion briefly turned to the goal of this part of the project. A member posed the question of whether the standards should push for changes in the standard of practice within the community. Or, should the standards and the investigative process identify those who are practicing significantly below the standard of care? Garrett reminded the group that DHS' position since the beginning is that disenrollment should be a very rare event, and that what the state needs from the OPWG is to understand the level of practice that is so bad that the clinician could be sanctioned. The quality improvement program is the opportunity to help clinicians practice more safely and meet community standards of care. Those who we investigate should be clinicians who are not participating in the community dialogue about how we view opioids as a society, and how we create a safer prescribing culture. There was consensus among the group that the disenrollment standards need to identify those who are not only failing to meet the standard of care, but are extreme outliers and creating unacceptable levels of risk.

A member shared his perspective that the disenrollment domains should be highly specific for bad practices. If a behavior is identified, then there is almost near certainty that the investigation will uncover bad practice. Members agreed, and asked DHS whether the OIG has clinicians who will be able to identify these bad practices based on chart review. DHS confirmed that this is part of the OIG investigative process.

The work group reached general consensus that the domains presented should be defined, and that a domain be added for failure to screen and appropriate treat mental health conditions. Chris Johnson moved to accept the domains as modified, Rebekah Forrest seconded the motion. Members unanimously voted to approve.

DHS staff will take volunteers to help develop the clinical definitions offline.

Quality improvement program update

Audrey Hansen provided an update on the quality improvement program. A copy of her slides is available upon request. First, she provided an update on the Special Cause Request for Review Process. Two key learnings from this work include:

- The information provided by clinicians was sometimes insufficient to understand the prescriber's practice patterns and/or patient population. Some of this was due to form design, which will be improved for 2022.

- There is limited understanding of MME and the existing community standards.

She also shared that the chronic pain human design work is in its final stage. All of the cohort meetings are complete, and now follow-up interviews are being conducted with participants for specific feedback on priority concepts. ICSI will share the work product with the OPWG in December. Hansen also addressed the resources available to the Qi participants, including an updated version of the ICSI Opioid Postoperative Prescribing Toolkit.

Meeting adjourned.