Opioid Prescribing Work Group

Minutes — November 18, 2021
12:00 pm –3:00 pm
WebEx Video Event

Members present: Emily Bannister, Kurtis Couch, Julie Cunningham, Kurt DeVine, Chris Eaton, Tiffany Elton, Dana Farley, Rebekah Forrest, Bret Haake, Chad Hope, Chris Johnson, Murray McAllister, Richard Nadeau, Adam Nelson, Saudade SammuelSon, Lindsey Thomas

Members absent: Nathan Chomilo, Matthew Lewis, Charles Reznikoff, Charles Strack

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

ICSI staff: Audrey Hansen

Welcome and introductions

Julie Cunningham called the meeting to order and welcomed members. Opioid Prescribing Work Group (OPWG) members introduced themselves. Members reviewed the October OPWG meeting minutes. Ellie Garrett called attention to a note in the minutes about a public comment made during the October meeting. Chris Johnson was accused of saying that it is easy to taper in a previous meeting. DHS staff reviewed meeting recordings, minutes and transcripts, and he did not state that. Chris Johnson commented that he said that tapering too quickly could be considered patient abandonment. A motion was made to approve the minutes, and the minutes were passed unanimously.

State agency updates

Garrett informed members that applications for the opioid epidemic response fund are now under review. This fund is directed by the Opioid Epidemic Response Advisory Council, but administered through DHS. DHS will also issue a request for proposal (RFP) for funding Integrated Care for High Risk Pregnancies (ICHRP) regional partnerships for American Indian communities. Finally, the COVID-19 Project ECHO has restarted. Garrett also took the opportunity to thank the OPWG members for their service.

Dana Farley echoed Ellie's comments about the talent, expertise and dedication of the OPWG members. It has been a great privilege to be a part of this. Farley shared that MDH is working with DHS and the Board of Pharmacy to develop community maps about overdose fatalities, nonfatal overdoses and opioid prescribing practices. This will be a helpful resource as counties and cities receive opioid settlement funds. He also shared that MDH has a pilot project about nonnarcotic pain management.

Opportunity for public comment

Cammie LaValle disclosed that she has no financial conflicts of interest. LaValle commented that there are a lot of unanswered questions about this project. Her primary question has to do with the chronic pain work being conducted by ICSI, with the support of DHS. Initially, this work was described as an ad hoc advisory committee that would be established to develop exceptions to specific prescribing thresholds. Can the OPWG make a definite statement that this did not happen? Rinn clarified that the question should be directed to DHS and responded. First, the purpose behind the proposed ad hoc committee was identify whether there are diagnoses, patients, and/or circumstances for which participation in the QI program may not be appropriate. DHS initially framed this work as a way to identify exceptions, however, as the work progressed it became clear that identifying certain situations for exception would not achieve the goals of the work.

Cammie identified three other questions she would like answered: 1) Will there be a response to the American Medical Association's response to the CDC chronic pain prescribing guidance; 2) Will there be a response to the CDC's Opioid Work Group recommendations for the update; and 3) Will DHS or MDH establish resources for patients who are abandoned or abruptly tapered?

Opioid Prescribing Improvement Program sanction standards

Rinn introduced this agenda item by reviewing the task set forth to the OPWG: develop clinical definitions of unacceptable practice as it relates to opioid analgesic prescribing. These practices may be subject to sanction by the DHS Office of Inspector General upon investigation. A copy of her slides is available upon request.

Failure to diagnose and respond to Opioid Use Disorder

Rinn presented a proposed definition for the domain: "A pattern of practice where the clinician who prescribes chronic opioid analgesic therapy (COAT) fails to assess or diagnose and respond to Opioid Use Disorder, when specific red flags for OUD are present." The underlined text will require specific definitions. Rinn presented a comprehensive list of red flags for OUD, and then proposed a narrower list to include in the definition. The proposed red flags included:

- History of overdose
- Known history of Opioid Use Disorder
- Active benzodiazepine use disorder
- Active alcohol use disorder
- Recurrent lost prescriptions, requests for specific opioids, or frequent early prescription requests

Members discussed additional behaviors and circumstances that may rise to such a high level of concern that they should be included. Acts of deliberate deception – including forging prescriptions, tampering with prescriptions or stealing from pharmacies – may be appropriate to include. A member cautioned that any one single instance of a behavior identified as a red flag is probably not sufficient. Members also discussed the need to include a timeframe in the definition. For example, 3 requests for early refills over a period of 6 months is more concerning than 3 requests over 10 years of treatment.

Members expressed concern about several of the red flags identified in the comprehensive list presented. Specifically, requests for specific opioids, delegating medication management to a family member, and arguing with a health care provider. Patients who experience chronic pain or breakthrough pain often know precisely

which opioid formulation works best for them. Members expressed concern that self-advocacy is misinterpreted as red flags for OUD. Other concerning red flags include driving while using opioid therapy to manage pain. There was consensus among members that not all of the red flags listed in the comprehensive list are useful for the sanction discussion.

Discussion about the proposed red flags continued, and members began to reach consensus that a timeframe needs to be added to the first two red flags in the proposed list, the third and fourth bullet are fine, the final bullet should be removed, the definition should include something about deceptive practices, and a pattern of behavior that indicates loss of control.

A member asked whether the DHS OIG team will need examples of behaviors that may indicate a loss of control. Melanie LaBrie confirmed that a short list of examples is helpful for investigations. The descriptors could include items that an OPWG member previous stated: a pattern of lost prescriptions, a pattern of demands for specific opioids or formulation with a change in the clinical condition, or a pattern of early requests. Including the word pattern is important. She also addressed previously stated concerns about patient requests for specific opioids, and stated that a discussion about which opioid works best for a patient is commonly documented.

A member cautioned the group about getting too far in the weeds about specific patient behaviors. These sanctions are directed at clinicians, and are meant to capture the situations that if a provider routinely ignores potential safety issues for the patient, the provider could be sanctioned. If a prescriber has a panel of patients with histories of overdose, unaddressed unexpected urine toxicology results, and/or contraindicated medication combinations, this clinician should be reviewed.

A brief discussion ensued about diversion, and failure to provide urine drug screens. The group agreed to move on to what the expected action should be when a clinician identifies red flags.

Discussion ensued about the level of screening or assessment needed when a prescriber suspects that the patient is developing an Opioid Use Disorder (OUD). Members discussed whether brief screening tools such as the TAPS is sufficient, whether a more comprehensive assessment is required, and how this should be documented. Members generally agreed that historically very little has been done to address suspected OUD, and there was emerging agreement that the OPIP sanction standard should set an expectation that the prescriber at least pursues the diagnosis if any of the red flags addressed earlier are present. It is not realistic to expect providers to make a formal OUD diagnosis, but there should be some disruption to the pattern of care if there is concern for the patient's safety.

Discussion continued about what the appropriate action should include. Members generally agreed that it is not sufficient to expect a bare minimum level of intervention, but had difficult agreeing what one step up from the bare minimum should constitute. A brief discussion ensued about access to assessment for chemical dependency, and the scope of resources available for such assessments. DHS staff proposed moving on to the next domain, and that staff and the small group would work on language for the intervention for review by the large group.

Failure to respond to serious risk factors for opioid-related overdose and serious adverse events

Rinn presented the draft clinical definitions for the domain: "*Initiating opioid therapy for chronic pain or continuing to prescribe chronic opioid analgesic therapy to a patient with <u>risk factors for opioid overdose or</u>*

serious opioid-related adverse events, and failing to identify the risk and create an action plan to reduce the risk." Proposed risk factors include:

- Symptomatic, untreated suicidality
- Symptomatic, untreated mania
- Symptomatic, untreated psychosis
- Nonfatal opioid overdose
- All cause emergency department visits in the past 6 months

Members then reviewed the RIOSORD, and the risk factors for serious opioid-induced respiratory depression included in that assessment. A member commented that alcohol use and an active substance use disorder are not included in the RIOSORD, but are serious risk factors for overdose. Discussion ensued about the prevalence of some of the proposed risk factors. Although the conditions associated with mania and psychosis are identified as significant risk factors for opioid-related harm, a member questioned their prevalence in the general population. The RISOSRD was developed at Veteran's Health Administration, and the prevalence of mental health conditions and other risk factors for overdose may be different in the general population, and specifically in the Medicaid population. A brief discussion ensued about whether to include risk factors that may pose a relatively smaller risk, but are so ubiquitous amongst patients that they should be addressed, e.g. sleep apnea.

Discussion turned to the proposal to include all cause emergency department visits in the last 6 months. A member commented that the description makes sense, in light of the fact that a nonfatal opioid overdose may not be diagnosed as such in the ED. Diagnoses are often very conservative, so the diagnosis is more likely to be sedation, etc. Members briefly discussed whether clinicians know if their patient has visited an Emergency Department or Urgent Care. A member commented that she specifically does not allow open access between the health systems where she receives care.

Meeting adjourned.