# Opioid Prescribing Work Group

Minutes — November 15, 2018
noon – 3:00 p.m.
444 Lafayette Building, St. Paul

**Members present:** Julie Cunningham, Chris Eaton, Tiffany Elton, Dana Farley, Rebekah Forrest, Ifeyinwa Nneka Igwe (remotely), Brad Johnson, Chris Johnson, Ernest Lampe (non-voting), Matthew Lewis, Pete Marshall, Murray McAllister, Richard Nadeau, Mary Beth Reinke (non-voting), Jeff Schiff (non-voting), Charles Strack, Lindsey Thomas

**Members absent:** Charlie Reznikoff

**DHS employees:** Titi Adeniyi, Ellie Garrett, Tara Holt, David Kelly, Sarah Rinn

**Guests:** Amber Bullington (#MNPain MN), Jim Cook (Mercer), James DaRosa (Pfizer), Kate Erickson (MDH), Pearl Evans (Minnesota Recovery Connection), Audrey Hansen (ICSI), Sheila Grabosky (chronic pain patient), Diane Keil (#MNPain MN), Diane Kelley (#MNPain MN), Mary Kuna (Don't Punish Pain), Cammie LaValle (Don't Punish Pain), Teresa Liesener, Jennifer Markoe (#MNPain MN), Kristin McGarity (Don't Punish Pain), Juliana Milhofer (MMA), Vanessa Percy (#MNPain MN), Tina Sanz (chronic pain representative), Sara Shadoost (Fon du Lac, PharmD student), Trudy Ujdur (Sanford), Lori VanBeusekom (chronic pain representative), Ron Van Beusekom (chronic pain representative), Lisa Wichterman (DLI)

## Welcome and Introductions

Chris Johnson called the meeting to order. Johnson welcomed members and guests, and introductions were made around the room.

## DHS Updates

Jeff Schiff thanked the OPWG members for their ongoing commitment to this work, and welcomed guests in the room. He provided a brief update on the status of opioid-related initiatives at DHS and in state government. First, the National Committee for Quality Assurance (NCQA) reviewed DHS' New Chronic User measure and adapted it to become a HEDIS 2019 measure, Risk of Continued Opioid Use. Second, DHS removed prior authorization for buprenorphine for treating Opioid Use Disorder (OUD). DHS is working closely with external partners to ensure that buprenorphine is used effectively and appropriately.

The federal government recently announced the State Opioid Response grant – the newest set of federal grant funding to states. The primary focus of the SOR funds is to expand treatment for OUD. The RFP for the SOR grants funds will be posted on the DHS Grants and RFP website.

## Approval of Minutes and Opportunity for Public Comment

Members unanimously approved the March 2018 meeting minutes.

## Opportunity for Public Comment

Kristen McGarity offered comments in person. Ms. McGarity shared her personal history with chronic pain and treatment history. She urged the OPWG to reconsider setting a ceiling dose limit of 90 MME/day. She cautioned that patients will be discouraged from self-reporting their functional status. She acknowledged that the existing evidence for long-term therapy for chronic pain is weak, but pointed out that many chronic pain patients are unable to sign up for studies. She also commented that overdose risk is more correlated to a patient's mental health condition, and that individual risk benefit analyses should guide dosage decisions. She commented that physicians are risk averse, and are interpreting the guidelines as rules.

Amber Burlington offered comments in person. She shared her personal history of chronic pain and treatment history. She told the group that a year ago a physician dismissed her from care, and then had her medication tapered. This left her bed ridden for about a year. She urged the OPWG to let prescribing decisions be made between a provider and the patient. Forced tapers are dangerous, especially when physicians are not trained on how to reduce dosage appropriately. She commented that providers need education, especially about appropriate tapering.

Jennifer Markoe offered comments in person. She shared her personal history of chronic pain and her treatment history. She commented that it is inappropriate for anyone but providers and their patients to make decisions regarding a patient's pain management. Most of the people abusing drugs are young, and abuse multiple drugs at a time. Alcohol use is involved with 50% of opioid overdoses, however there is a lack of education about the dangers of using multiple drugs and alcohol. Opioids are not appropriate for everyone, but this should be a provider's decision about how to prescribe.

Diane Keil offered comments in person. She concurred with previous statements made by public participants. She commented that she would not be able to live alone without her current treatment options, and that physicians and their patients should make treatment decisions.

Vanessa Percy offered comments in person. She shared her personal history of chronic pain and treatment. She is concerned about the black and white nature of recent opioid prescribing policies. She shared her research into pharmacogenomics, and how it effects an individual's ability to process opioids. She advocated for individualized care decisions, and advancing awareness of pharmacogenomics.

Cammie LaValle offered comments in person. She then shared her personal history and history of treatment. Although she is exempt from the guidelines, she is very concerned that her providers are misinterpreting the guidelines. She shared her concern that there is no reference to intractable pain in the Opioid Prescribing Guidelines, and stated that patients with intractable pain should be exempted. Ms. Lavalle then called attention to two recent national initiatives to limit the use of dose ceilings: the American Medical Association (AMA) resolution 235 and the HHS Pain Management Best Practices Inter-Agency Task force draft recommendations. She urged the OPWG to acknowledge the rare disease community, and to take note of the recent AMA and HHS statements.

Tim Boyd from Nation Organization of Rare Disorders (NORD) offered comments in person. The NORD represents patients with rare disorders. Many rare disorders cause intractable pain, and do not have a cure. He supports patients' call for greater awareness of rare disorders, and offered assistance to the state and OPWG.

Tina Sanz offered comments in person. She first acknowledged the work of the public members who traveled to the meeting. She then shared her personal history and history of treatment. Ms. Sanz commented on the rising use of illicit opioids, and the rising rate of related overdose deaths. The chronic pain community has great sympathy for those lost to addiction and OUD, but that population is different from the chronic pain community who is carefully monitored and managed. Patients who are responsibly using long-term opioid therapy should not have treatment decisions made based on what is occurring with illicit opioids. She commented that opioid therapy allows her to work, have a home and a normal life. She urged the OPWG to make an exception for rare diseases, for individuals with chronic pain, and for those who have exhausted other therapies.

Schiff thanked all in the room who offered comments. He shared with the guests that the work group is now tasked with developing the quality improvement program, and that will impact provider's response to this program. He also acknowledged the need for special cause exemption for providers, and that will be defined over the next few OPWG meetings.

Matthew Lewis also thanked individuals who shared their story. He briefly shared his personal history with pain and OUD, and acknowledged how difficult it is to tell your story. Dana Farley also thanked members of the public for sharing their personal history and commented on his experience with chronic pain.

Rinn reviewed the agenda for the meeting. A copy of her presentation is available upon request.

## Prescriber Reports Update

Rinn reviewed updated opioid prescribing data for the seven opioid prescribing sentinel measures. A member of the public asked whether there is data about the prevalence of medical conditions treated with high-dose chronic opioid therapy. Rinn answered that it is very difficult for DHS to obtain that level of detail through administrative claims. The program is designed so that the data serves as the flag for potential outliers, and then DHS will engage with those providers to better understand their practice and patient panel. Another public member commented that pain medicine physicians are the only providers who will accept them as their patients.

A brief discussion ensued after reviewing the concomitant opioid and benzodiazepine prescribing measure. Members expressed concern shared by the medical community about how to engage the benzodiazepine prescriber, and who to reach out to when prescribing does not change. Members of the public requested additional explanation of the multiple prescriber measure. Rinn stated that this is not a quality improvement measure, but that the work group and state believe it is valuable information to share with providers. The measure specifically captures patients receiving COAT from one prescriber, who also receive overlapping opioids from at least two other providers.

A member of the public commented on the confusion that is occurring in the medical community. She commented on pharmacists refusing to fill prescriptions. She cautioned the work group about disconnect between the work group's discussion and what is actually happening in the community to pain patients. Another member of the public commented on being accused of doctor shopping within the same clinic.

Discussion turned to an update about the opioid prescribing reports. Rinn briefly walked through the report. A brief discussion among work group members and members of the public occurred about patient abandonment and forced tapering. DHS staff told public members that the intent of quality improvement is not necessarily to

lower prescribing rate to the median. For some providers—especially within the COAT measures—the expectation will be that providers demonstrate appropriate risk mitigation for patients on long-term opioid therapy.

Rinn provided details about how the reports will be sent to enrolled providers. DHS will use the MN—ITS mailbox to send the reports, and provide training to providers about accessing and using the system. A member asked whether DHS can track if providers open the email. DHS staff indicated it is possible, but it may be difficult to do it on a large scale (16,000 reports). Another member asked whether the email provides two-way communication. Rinn responded that we will have a formal response mechanism. It will include routing calls through our provider call center, as well as an online feedback mechanism.

Prior to the break, a guest commented that there are no chronic pain patients on the OPWG. She expressed concern that her perspective is not represented. An OPWG member commented that all meetings are public and that chronic pain patient community has been engaged throughout the life of the project.

## Provider Education Updates

Rinn provided a brief update about the prescriber education campaign. The campaign will launch in the beginning of the year and include CME credits through collaboration with the University of Minnesota and the Minnesota Medical Association, online resources, a brief video highlighting a successful change in approach to opioid prescribing, and other tools.

## Quality Improvement Program

Rinn presented data about the number of providers flagged for a quality improvement review, based on 2017 prescribing data. The data is available upon request. She provided work group members with the number of prescribers required to participate who wrote 5 or more opioid prescriptions during the year, and the number required to participate who wrote 10 or more. Rinn also presented the number of providers flagged to participate, by sentinel measure. Members reviewed the data, and discussed the merits of the various opioid prescription volume thresholds. Consensus emerged around using 10 or more prescriptions as the cut-off for quality improvement participation, but members asked to see the data using additional, larger thresholds.

Discussion turned to the timing of the data. Several members expressed concern about using 2017 prescribing data in the first set of reports. Significant work has been done across a number of health systems in the state to reduce prescribing rates. Members are concerned that using the 2017 data does not provide an accurate representation of the current landscape. There is also concern that providers will not be happy if they are flagged for QI based on data that is a year old. DHS staff will look into the possibility of using 2018 data. The claims run out process (time until all claims are processed) is faster for pharmacy data, but that the analysis also uses medical claims to identify patients exempted based on a cancer diagnosis or receipt of hospice services. The state generally uses a 6 month run-out for medical claims.

Rinn provided an overview of the plan to develop the quality improvement program. The first task of the work group is to identify activities that should be included in a provider's quality improvement plan. She also shared resources developed by AHRQ around opioid prescribing quality improvement in primary care settings.

A brief conversation between the work group and members of the public occurred. A guest asked about the process for providers who are flagged for quality improvement. Rinn explained the quality improvement process, and the process for developing termination standards for providers who do not comply. A member of the public then asked whether the state can punish providers who are misusing the guidance to dump patients. Several members of the public expressed disbelief that providers will continue to treat their chronic pain patients.

The meeting concluded with a brief working session. Work group members discussed quality improvement activities in small groups, and the group briefly reconvened before adjourning. Members discussed the importance of strong leadership, champions, strong administrative support, and education for all team members. It is important that the QI activities are scalable for practices. Meeting adjourned.