Opioid Prescribing Work Group

Minutes — March 21, 2019
noon – 3:00 p.m.
444 Lafayette Building, St. Paul

Members present: Julie Cunningham, Tiffany Elton, Dana Farley, Rebekah Forrest, Ifeyinwa Nneka Igwe (remotely), Brad Johnson, Chris Johnson, Ernest Lampe (non-voting), Matthew Lewis, Murray McAllister, Richard Nadeau, Charlie Reznikoff, Jeff Schiff (non-voting)

Members absent: Chris Eaton, Pete Marshall, Mary Beth Reinke (non-voting), Charles Strack, Lindsey Thomas

DHS employees: Charity Densinger, Ellie Garrett, David Kelly, Sarah Rinn

Guests: Sheila Grabosky (chronic pain patient), Audrey Hansen (ICSI), Vanessa Percy (chronic pain patient), Trudy Ujdur (Sanford)

Welcome and Introductions

Chris Johnson called the meeting to order. Introductions were made around the room.

DHS Updates

DHS staff provided a brief update on two opioid-related issues. First, Jeff Schiff reported that state staff completed reviewing the State Opioid Response grant applications received. Final decisions about grant allocations will be made shortly. Second, Ellie Garrett provided a status update on the two opioid stewardship bills in the state legislature.

Approval of Minutes

Members unanimously approved the February 2019 meeting minutes.

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

Opportunity for Public Comment

Sheila Grabosky (individual with chronic pain) thanked the work group for the opportunity to comment. She provided a brief overview of her pain history. Ms. Grabosky expressed concern about disincentives to manage chronic pain with non-opioid treatment, lack of access to nonpharmacological treatment options, and the limited number of pain medicine providers. She expressed frustration that when she becomes eligible for Medicare, she will lose access to treatment modalities. She encouraged the work group and the state to think of creative solutions to improve access to pain medicine providers and treatment options. One of the solutions she suggested was tuition reimbursement or loan forgiveness for providers treating patients with chronic pain.

A second person requesting the opportunity to provide public comment was delayed in transit. The work group agreed to have a second public comment period after the break in the agenda.

Public Comment Policy

Public comment policy

Schiff introduced a draft public comment policy for the members' review. The draft formalized the existing public comment policy, and added a requirement for individuals providing comment in person. Individuals who wish to have their public comments summarized in the meeting minutes must provide a written copy of their comments (less than 2 pages) prior to the meeting. Individuals who do not provide written comments are welcome to speak during the public comment period, but their comments will not be included in the meeting minutes. Members briefly discussed the revised public comment policy and offered two revisions. **First, add the mission or the charge of the Opioid Prescribing Work Group to the document.** This will help people understand the authority of the OPWG, and how the work fits into the overall state response. **Second, modify the language used to describe the length of the public comment period.** Instead of stating that the public comment period shall not exceed 15 minutes, state that the period generally lasts 15 minutes or less.

Members briefly discussed the importance of collecting and vetting disclosures of financial conflicts of interest in medicine. This is currently an important topic on journal boards, within professional organizations, and in regulatory bodies. A member suggested that DHS should provide comprehensive information about how the public is able to engage the state and members about the Opioid Prescribing Improvement Program, beyond providing public comments at the meetings. It is important to acknowledge the significant volume of input that has been received about the program, and that is expected to continue with implementation of the quality improvement program. Rinn reviewed the proposed changes to the public comment policy document. She will revise document, and submit it to DHS communications for review. **A motion was made to approve the public comment policy as amended. The vote passed unanimously.**

DHS response to public comments

Rinn introduced a response from the state to public comments made at the February 2019 OPWG meeting. She briefly reviewed the comments made during February meeting, and explained that both DHS staff and OPWG members recommended responding to erroneous claims made about the program. Rinn reviewed the factually incorrect statements, and the state response to those claims. Members briefly discussed the response, and in general found the state response to be helpful. A request was made to turn the document into a general FAQ about the program. A member suggested revising the answer in number ten to acknowledge that institutions are responding with prescribing limits, but that is influenced by a number of factors (not just the OPIP). A member commented that prescription limits in organizations are often instituted by pharmacy and therapeutics (P&T) committees. It is difficult to draw a straight line from the work group to a P&T-influenced policy.

The discussion then turned to concerns raised about forced tapering. The work group members acknowledged the potential for harm associated with forced tapers, and the significant potential for harm for patients who are on extremely high daily doses. DHS staff confirmed that the Opioid Prescribing Improvement Program does not support forced tapers. Members discussed the importance of education around tapering; providers must share what they know with patients and consistently aim for shared-decision making.

Schiff commented briefly about intractable pain and the OPIP. Members were provided with a copy of the Minnesota intractable pain statute. Schiff clarified that disciplinary action referenced in the statute is related

to the Board of Medical Practice. Providers who treat intractable pain with opioid therapy cannot be disciplined for appropriate opioid prescribing, and it is the Board's role to determine whether the practice is within the standard of care. This is distinct from the OPIP, which is a quality improvement program for Minnesota Medicaid and MinnesotaCare providers.

OPIP Program Updates

Rinn provided a brief update on three opioid-prescribing issues recently in the national news. First, there is ongoing communication between Senator Wyden (D-OR) and DHHS Secretary Azar about the vetting process for financial conflicts of interest among the HHS Interagency Pain Management Best Practices Task Force members. A member of the public requested that DHS send the response from the AAPM President to the OPWG members. Rinn confirmed she would do so after the meeting. Second, the Health Professionals for Patients in Pain (HP3) wrote a letter to Centers for Disease Control and Prevention (CDC) calling on the agency to address misapplication and misguided implementation of the guidelines. Third, the American Academy of Pain Medicine published a consensus report about challenges associated with implementing the CDC opioid prescribing guidelines. Copies of the materials were provided in the meeting folders.

Rinn turned to OPIP program updates. The Flip the Script campaign launched two weeks ago. DHS is extremely appreciative of Dr. Paul Kietzmann and his patient Patricia for their willingness to participate. The campaign materials are available on the new OPIP web site, under the Provider Education tab. DHS is now preparing to send out the opioid prescribing reports. In the next week, DHS will send out instructions to providers about how to register their MN—ITS mailbox. A training module will also be available to help providers access their folder and report once their mailbox is created. Providers who are only enrolled via a managed care organization will receive their opioid prescribing report via the U.S. Postal Service. Rinn also informed groups that DHS is creating on online feedback process for providers with questions or comments about the reports.

Measure update

DHS staff provided an update on modifications made to the chronic opioid analgesic therapy sentinel measure definitions. The data analysis team identified a minor issue in the definition for a split-dose opioid therapy (two different opioid formulations prescribed on the same day), and resolved the problem. The team also reviewed the definition of a chronic opioid analgesic therapy patient, based on concerns that the current definition would miss COAT patients who receive prescriptions from different providers within a practice. Previously, an enrollee was a COAT recipient if they received ≥ 60 consecutive days' supply of opioid therapy from a single prescriber. DHS proposes revising the measure to make it more patient-focused, including all patients who received ≥ 60 consecutive days supply of opioid therapy (a COAT span), regardless of the number of prescribers who contribute to COAT span.

DHS staff analyzed the impact of removing the requirement that the same provider prescribe the entire COAT span. There was a significant increase in the number of providers identified in measure 4—frequency of prescribing chronic opioid analgesic therapy—but there is nominal impact on the number of providers identified as prescribing high-dose opioid therapy or concomitant opioid and benzodiazepine therapy. DHS proposed removing prescribers who prescribe < 7 days of opioid therapy to a COAT patient, in order to avoid including prescribers of short-term treatments in the quality improvement program. Discussion ensued about the proposed changes. One issue identified was including providers who prescribe short bursts of opioid therapy in the chronic opioid quality improvement activities. This type of prescribing consists of a different set

of skills from prescribing chronic opioid analgesic therapy. This difference may be addressed by the peer groupings, but DHS staff will review the data to better understand the impact.

Public Comment Period

A second public comment period occurred after the break. First, Ellie Garrett read aloud comments received by Susan Deneffe (chronic pain patient). Ms. Deneffe provided a brief overview of her medical history and experience as a pain patient. She has significant concerns about being able to manage her pain adequately in the future, given that her physician is requiring her to taper due to concerns about losing his practice. She requested that guidance for pain medicine providers stress the necessity of individualized treatment plans and decisions.

Vanessa Percy (chronic pain patient) provided public comment. She shared a brief overview of her medical history and her experience as a chronic pain patient. She expressed concerns about the increased burden on pain clinics. She stated that she is unsure about what to do as a chronic pain patient, but that her goal is stabilize her pain. She thanked the work group for the opportunity to provide feedback.

Quality improvement Activities

DHS staff introduced the discussion by asking the work group members for a brainstorming session on the quality improvement activities. Over the course of the next several months, DHS staff will refine the quality improvement activity requirements. The OPWG will break during the summer, and then reconvene to vote on the quality improvement components.

A member commented that this process must be very accessible to providers. Not every practice will understand what to do, so there will likely need to be some education around adaptive change. Discussion turned to the idea of adaptive change. One of the goals of the QI program should be to challenge providers to sit down and look at prescribing in the practice. A member commented that this type of work is not reimbursed, which presents a barrier. Someone suggested reframing the issue as an adverse event, given that it is standard procedure to review adverse events within a practice. Audrey Hansen (ICSI) commented that adaptive change is about more than identifying a pattern of behavior, but also recognizing that it can be changed. Recognizing that change is possible may be more about communication skills, and learning about pain. It is very important that the organization is engaged in order to address organizational barriers and provide support.

Discussion turned to whether the QI program requires participation among individuals, organizations or both. The consensus in the room was that it requires both. Schiff responded that the task is to put out a quality improvement process. The state's role is to identify the components of that model, e.g. case reviews, education, etc. The state does not need to be part of those reviews, but does need some kind of confirmation that the reviews occur.

There was emerging consensus that the quality improvement program requires flexibility, with some guidance. It is important the program is not too prescriptive, given that it will apply to a broad number of provider types and practice types. Discussion briefly turned to the quality improvement timeframe. DHS recognizes that quality improvement will likely be a multi-year effort, and that interim data reports may be needed. The work group members agreed to continue the discussion in April.

Meeting adjourned.