Opioid Prescribing Work Group

Minutes — April 18, 2019
1:00 – 3:00 pm
444 Lafayette Building, St. Paul

Members Present: Julie Cunningham (remotely), Sen. Chris Eaton, Tiffany Elton (remotely), Dana Farley, Rebekah Forrest, Ifeyinwa Igwe (remotely), Ernest Lampe, Matthew Lewis, Pete Marshall, Richard Nadeau, Charles Reznikoff, Jeff Schiff, Lindsey Thomas

Members absent: Brad Johnson, Murray McAllister, Mary Beth Reinke, Charles Strack

DHS employees: David Kelly, Sterling Kowalski, Sara Lent, Justine Nelson, Sarah Rinn

Guests: Amber Bullington, Lisa Wichterman (DLI)

Welcome and Introductions

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

DHS Updates

Jeff Schiff provided a brief update on the federally-funded opioid response grants. DHS received approximately 90 proposals for this round of funding. The funds include $17 million of State Opioid Response (SOR) grants, $7-$8 million of State Targeted Response and an additional $4.3 million supplement to the SOR grants. DHS appreciates the robust response to this grant cycle.

Senator Chris Eaton shared that the Opioid Stewardship bill passed the House and Senate. Both versions of the bill raise $20 million a year and require a new advisory body. Senate and House leaders now have to address key differences in the bill, including any sunset provisions.

Approval of Minutes

Members unanimously approved the March 2019 meeting minutes.

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

Opportunity for Public Comment

OPWG members reviewed public comments from four individuals.

Kristi McGarity submitted three reviews from the medical literature in response to a Minnesota DHS statement on KARE 11 regarding the efficacy of chronic opioid therapy for non-cancer related chronic pain. Ms. McGarity also provided recent statements from the US Food and Drug Administration (FDA) and Centers for Disease Control and Prevention (CDC) regarding cancer exceptions for chronic pain therapy and clarifications to the

CDC prescribing guidelines, respectively.

Sheila Grabosky (chronic pain patient) provided four comments about the project. First, the chronic pain patient community should be represented on the work group. Second, she expressed concern about whether physicians will participate in the quality improvement program if there are consequences for participation. Third, she is unable to determine whether the state has set a goal for reducing opioid prescriptions. Fourth, there should mandatory patient education prior to beginning opioid therapy.

Sara Donadei (chronic pain patient) submitted an email to the work group members expressing her concerns. She expressed concern that she will lose access to her opioid therapy, and that this should only be a decision between her and her physician.

Cammie LaValle (chronic pain patient) expressed serious concern that palliative care patients are being forced to taper their opioid medications as a result of state policy.

Quality Improvement Discussion

Rinn provided a brief update on the opioid prescribing reports. The reports are ready for distribution, and DHS is finalizing the technical requirements for distribution. DHS will provide updates on the distribution mechanisms after the April Opioid Prescribing Work Group (OPWG) meeting.

Schiff introduced the conversation on quality improvement activities by reviewing the three categories of activities discussed in previous meetings: 1) education; 2) technical; and 3) adaptive work. The goal of this meeting is to gather ideas for the quality improvement (QI) process. DHS will then synthesize and refine the materials for the fall 2019 OPWG meetings. DHS asked three of the work group members to briefly present the QI work underway in their organizations.

OPWG Member Presentations

Iphie Igwe provided an overview of Essentia's opioid prescribing dashboard in their EPIC electronic health record system. Essentia uses 20 retrospective prescribing measures for acute pain, post-operational pain and chronic pain. The dashboard provides six indicators of opioid prescribing at the provider level, and providers are able to drill down into each indicator. The dashboard also provides a link to the Prescription Drug Monitoring Program (PMP) and prescribing guideline information. Members discussed Essentia's process for addressing outliers, and the patient care metrics for chronic opioid therapy prescribing. Essentia has seen significant decreases in prescribing since implementing the dashboard.

Julie Cunningham provided an overview of Mayo's enterprise opioid stewardship efforts. Global efforts include the formation of a work group, and development of required education for providers, nurses and pharmacists. Mayo developed acute and chronic prescribing guidelines within their organization. Mayo also created an opioid dashboard that is available at the prescriber and department level, and created a standardized patient provider agreement from.

Tiffany Elton (Min No Aya Win Human Services Center) provided an overview of Fond du Lac Human Services'

work on opioid therapy. Changes within the system are primarily driven by provider champions. The clinic adopted the Minnesota opioid prescribing guidelines, and peer performance feedback adheres to the guidelines. There has been a 7 fold reduction in opioid dispensing from 2011 to 2018. Members discussed patient retention within Fond du Lac's health care system. Elton shared that two features of their system—the ability to offer wrap around services in house and monitor patients across different departments—assists in patient retention and stability.

Quality Improvement Discussion

Chronic Opioid Analgesic Therapy

Discussion then turned to the OPIP quality improvement process for chronic opioid analgesic therapy (COAT). A member asked whether the intent of the QI process is to: 1) have participating providers reduce their numbers below the threshold; and/or 2) ensure that all safety checks are in place because their prescribing rates are above threshold. Members agreed that the intent is to do both.

Members discussed the educational requirements for the QI program. First, a member expressed his strong belief that providers who prescribe COAT should be able to make an addiction diagnosis and counsel patients on appropriate next steps. Screening patients with an opioid misuse tool is not a sufficient response. The provider has to engage in a meaningful way, which will likely require education and training around communication tools to engage with patients. However, the requirement does not need to be that the providers are addiction experts. Members briefly discussed what is considered a well-educated provider and directed the state to frame the requirement with this in mind. Providers need basic proficiency in knowing the signs and symptoms of opioid use disorder.

A brief discussion ensued about the need for providers to better understand the pathophysiology of opioids and pain physiology. This could include brief education about the difference between tolerance and addiction, and withdrawal mechanisms. There was opposition in the room that this level and type of education will not explicitly modify the outcomes associated with the OPIP measures and reports.

A proposal was made to create a targeted QI process for this project that focuses on a few critical outcomes. The project would require providers to focus on their ability to identify patients at high risk for OUD and lower their risk. This would include identifying chronic pain patients on opioid therapy with untreated or undiagnosed mental health conditions.

Members then turned to the technical requirements of the QI process. Igwe described some of Essentia's workflows for chronic pain patients, including: a pharmacy intern runs the PMP check and attaches it to the patient visit; smart sets tailored to different types of COAT patients; different office length visits; and various dosage alerts. Members indicated that these types of operational policies are what should be included in the QI project. Members also expressed interest in technical requirements to improve patient retention in care, e.g. system alerts when a patient has not been seen within a certain time frame. A question came up about whether there is a technical fix to reduce dose escalation.

The work group then discussed adaptive change processes for COAT. Chronic opioid therapy and benzodiazepine therapy may be appropriate to address with adaptive change processes. The QI could include appropriate screening, and treatment or referral for non-pharmacologic therapy. This would also include communication with the mental health provider about expectations for those on opioids. Discussion then

turned back to the imperative for good interpersonal skills and the difficulty associated with these conversations.

The work group then briefly talked about tapering. Work group members expressed the need to have explicit, direct language about tapering expectations and requirements. Consensus was emerging that the statement can be neutral and that it may emphasize the importance of maintain and not escalate doses for certain COAT patients. Members expressed concern that providers need to know what a taper is, be able to justify it, and know how to do it safely and appropriately.

Acute and Post-Acute Pain

Members discussed the QI requirements for the acute and post-acute pain prescribing measures. A member asked the work group and state to separate acute pain and post-acute pain into two separate categories for quality improvement. The patient group in the post-acute pain phase is enriched with morbidities that are not necessarily in the patient group for acute pain. The two pain phases have a different set of risks, and require a different set of skills to lower risk. The QI activities for acute pain should focus on the current accepted indications for opioid therapy, and appropriate dosage. The member cautioned that the group must be extremely careful about risk assessment of acute pain. There is genuine concern that the message may be interpreted that people with past trauma should receive fewer opioids than those without. Risk assessment and screening is appropriate in the post-acute pain phase.

Discussion turned to the challenges associated with adaptive quality improvement work for certain specialties and providers. The group briefly discussed the ECHO program as a tool for peer-to-peer learning, especially for rural providers. Members questioned whether cross-peer learning is achievable for dentists, given the prevalence of small dental practices throughout the state. Nadeau shared that potentially effective ways to reach dentists is through continuing education and pharmacy colleagues.

Members briefly discussed the educational and technical requirements for acute and post-acute pain. Schiff indicated that for the post-acute pain technical changes, the intent is to ask providers to show us how the incorporate appropriate risk assessment and re-assessment of indications for opioids. The state does not want to see the actual results.

Chronic Opioid Analgesic Therapy Measure

David Kelly briefed the members about changes to the COAT prescribing measures. Under the existing methodology, COAT was defined as a 60-day consecutive supply from one provider. Given concerns that the state was missing COAT patients under this definition, the change was made to define COAT as a 60-day consecutive supply from any provider. The change affects each COAT measure as follows:

- Measure 4 (frequency of prescribing COAT): The denominator is the number of patients to whom the provider prescribed at least one opioid prescription. The numerator is now the number of patients who had at least one 60-day consecutive supply of opioids therapy. In other words, the measure identifies how often was the provider involved in prescribing opioid therapy to a COAT patient.
- Measure 5 (high dose COAT) and Measure 6 (Concomitant opioid and benzodiazepine therapy: The numerator for measure 4 is the denominator for measure 5 and 6. However, in order to have a patient attributed to the provider's numerator, the patient must satisfy the measure-specific conditions AND the opioid prescription must have been at least a 28 days' supply. Therefore, if a provider writes a

prescription to a COAT patient for a short duration (post-op, weekend supply, etc.), that provider will not have the patient assigned to their numerator if the script was shorter than 28 days.

Meeting adjourned.