# Opioid Prescribing Work Group

Minutes — February 25, 2021
12:00 pm – 3:00 pm
WebEx Video Event

**Members present:** Nathan Chomilo, Kurtis Couch, Julie Cunningham, Kurt DeVine, Tiffany Elton, Dana Farley, Rebekah Forrest, Bret Haake, Chad Hope, Chris Johnson, Murray McAllister, Richard Nadeau, Adam Nelson, Charlie Reznikoff, Saudade SammuelSon, Charles Strack, Lindsey Thomas

**Members absent:** Sen. Chris Eaton, Matthew Lewis

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

## Welcome and introductions

Julie Cunningham called the meeting to order and welcomed members. Opioid Prescribing Work Group (OPWG) members introduced themselves. Members will review the January 2021 meeting minutes at the next OPWG meeting.

## State agency and program updates

Ellie Garrett provided a brief update on the recent State Opioid Response federal grant. Applicants have been contacted, and the state is entering into contract negotiations. DHS staff are also heavily involved in the legislation session.

Jessica Hultgren provided an update on the Opioid Prescribing Improvement Program (OPIP) quality improvement (QI) timeline. A brief discussion ensued about the QI liaison role, and specifically whether they will know the identity of providers required to participate in QI activities in their organization. Members expressed some concern about individuals in the liaison role knowing this information. DHS staff explained that each health system will determine who should be made aware of the QI providers. DHS intends to send the data to clinical leadership (medical directors). The process will be tailored to the system's preference.

## Prescribing guidance for chronic pain update

Sarah Rinn presented the proposed changes to Section IV of the Minnesota Opioid Prescribing Guidelines: Prescribing opioid therapy for chronic pain. A copy of the presentation is available upon request. The intent of the proposed changes is to update the prescribing guidance to align with the revised taper guidance.

Members discussed the changes to the first paragraph of the introduction. There was consensus among the members to modify the paragraph so that it states the prescribing clinician should be responsible for the management of conditions that contribute to the patient's pain, but the word "all" before the word

"conditions" should be removed. Members also agreed to add abrupt discontinuation of opioid therapy to the list of opioid-related risks in the first paragraph. A member proposed the following language (changes in bold):

*"*While the safest possible course of treatment is to avoid initiating chronic opioid analgesic therapy (COAT) for chronic pain, patients receiving COAT must be carefully managed to mitigate the potential for opioid-related adverse effects. The risks and harms associated with chronic opioid use are well known. These include increased rates of falls, fractures, constipation, delirium, pneumonia, sleep disordered breathing, endocrine dysfunction, opioid misuse, opioid use disorder (OUD), non-fatal overdose and overdose deaths. However, in the existing pain management environment, patients receive opioids for chronic pain and some clinicians will continue to use opioids as a component of pain management. **In this context, it must be recognized that abrupt cessation of opioid therapy is also a risk, and may cause significant patient harm.** Clinicians must recognize that the decision to prescribe opioids for chronic pain requires: ongoing, active risk assessment; frequent monitoring; responsibility for that patient's safety and management of ~~**all**~~ of the conditions that contribute to the patient's pain experience."

Rinn reviewed the other changes proposed to the COAT guidance. A motion was made to approve the changes—including the revisions to the introduction—and the vote was approved.

## Key messages: Opioid prescriber reports and cover letters

Hultgren reviewed three key messages included in the 2020 opioid prescriber reports. A brief discussion ensued about the last sentence of the introductory paragraph on the report. The sentence stated "Do not interpret this data as a reason to abruptly change how you opioid therapy for individual patients". Members discussed the fact that this should apply to individual patients on COAT, given that there are some clinicians who can and should be able to quickly correct overprescribing for acute pain. Members offered a number of options. A motion was made to revise the sentence to state: "Do not interpret these data as a reason to abruptly change how you manage individual patients on chronic opioid therapy." Member unanimously approved the change.

A members asked about instances in which the clinician is over the QI threshold for a measure that is not included in Year 1, or instances in which the clinician is over the QI threshold but not over the volume threshold. DHS staff responded that that information is included in the cover letter. DHS staff also clarified that the QI status box is highlighted on the report (not just highlighted for the purpose of the meeting). Hultgren asked members to review the cover letters at their convenience, and submit any questions or comments to the OPIP staff by March 5.

## Opportunity for public comment

Malia Cole provided public comment. She is a patient with chronic pain, and did not report any financial conflicts of interest. Ms. Cole provided a brief history of her pain management, and is now undergoing a nonvoluntary taper. Her quality of life has significantly decreased. She expressed significant concern about the medical community moving to taper people off of their opioid therapy, prior to figuring out how to expand access to non-opioid pain management options.

Sheila Grabosky provided public comment. She is a patient with chronic pain, and no financial conflicts of interest to disclose. She informed the group that her insurance company just stopped covering her current

pain medication, and recommended switching to another class of opioids that are not supported by her pain doctor. She expressed concern that the work group still does not understand people who have chronic pain.

The last public comment was provided by a man named Ty, who declined to share his last name. Ty is a friend of Gregory Ulrich, the man who committed the Allina clinic shooting on February 9, 2021. Ty briefly shared Mr. Ulrich's history of medical treatment for painful conditions, struggles with substance use, and frustration with the health care system. He shared that everyone is too concerned about people in pain becoming addicted, which he believes is the wrong concern. Ty shared that Greg did what he did because he was unable to get any help, and is the victim of state efforts that cut people off their medications.

Dr. Chomilo thanked all three individuals for their public comment. He recognized that this is hard conversation to have, but stated that the victims of the Allina clinic shooting were the woman who lost her life—Lindsay Overbay--and those who were injured and traumatized, including Jennifer Gibson, Sherry Curtis, Tammy Schaufler, Antonya Fransen-Pruden and others.

After a brief break, Kurtis Couch addressed the public comment. He supports the comments provided by Ms. Cole and Grabosky. While he does not support some of Ty's comments, he commented that it shows the frustration among chronic pain patients. Couch shared concerns about chronic pain patients being treated like 'junkies', acquiring massive debt to a lack of insurance coverage for pain treatments, and having to live with unbearable pain. He commented that the general public does not understand what it is like to live with daily pain. The pendulum swung too far away from using opioid therapy for chronic pain, and we should be trying to get it back to the middle.

## Data analysis review: Monitoring changes in prescribing for Measures 5 & 6

Rinn presented an overview of a recent data analysis conducted by the OPIP team. The purpose of this analysis was to explore whether there are any "red flag" metrics within Measure 5 (Rate of prescribing high-dose chronic opioid analgesic therapy (COAT)) and Measure 6 (Rate of prescribing concomitant opioid and benzodiazepine therapy). The first step in the analysis—which was presented—of the review the measure 5 and 6 prescribing data for providers flagged for quality improvement (QI) anytime between 2016 and 2020. A copy of the slide presentation is available upon request. In general, the data shows relatively stable prescribing among this group of providers. There are a handful of cases where the data increased or decreases significantly, indicating that the provider either ceased prescribing high-dose opioid therapy or concomitant opioid therapy, or significantly expanded his or her patient panel.

Discussion ensued about the data. The members discussed that when a Medicaid enrollee loses their Medicaid coverage, it can look like their opioids were abruptly terminated, but we cannot know what happens once they are no longer an enrollee. Discussion then turned to whether it is possible to use this data to understand what is happening to patients of providers who stop prescribing. A member commented that the highest prescribers he works with are typically older, male physicians who are near retirement. It is important to know what happens to their patients once they retire, especially since younger providers may be less willing to continue patients at high daily doses. The data presented in the graphs does not provide enough information about what happens to the patients of providers who stop prescribing.

A member commented that his hope is that if the work group creates goals, targets or metrics around the quality improvement program, than there needs to be data that can demonstrate whether a provider is

achieving those goals safely. The data presented at the meeting is interesting, but it does not provide enough information about whether the provider is changing practice responsibly. Is there a metric that will help the state identify providers who are responsibly meeting the program goals, and those that are not? OPWG members and OPIP staff were consensus that this data analysis is not likely to help us achieve that goal.

A brief discussion ensued about directly engaging with clinician to better understand changes in practice. A member suggested that if DHS is able to directly engage with clinicians, an option is to develop a set of roughly 10 standardized questions for the clinician which could be tracked quantitatively. DHS could incorporate the questions into the QI process. The discussion then turned to how to determine whether this work is improving patient outcomes. Currently, we are unable to measure patient outcomes so it is not known whether this project is improving it or worsening it. If the OPWG were to re-write the metrics today, it is likely we would have developed a measure about abrupt discontinuation.

Members asked DHS whether the state ever engages directly with enrollees via satisfaction surveys. Garrett responded that this is something the state would need to discuss with others outside the team. We are unable to directly target patients, given the private nature of the OPIP data, but there is likely other opportunities to explore. There is some concern about DHS' bandwidth to do this right now, but we will look into it. A member commented that there are also other health care utilization data points DHS could track that are associated with poor prescribing – including Emergency Department use, hospitalizations, psychiatric hospitalizations, etc. More desirable health care utilization measures may include utilization of pain rehabilitation programs, physical therapy, cognitive behavioral therapy, acupuncture, etc. These are not perfect variables, but they are possible to track.

Conversation then turned back to the data presented. A member asked if it is possible to look at the range of dose reduction over time (delta opioid dose). For example, can we analyze whether a patient in a given time period had a 40 MME dose reduction vs a 4 MME dose reduction, and then what is the range of those dose reductions in a given time frame. The mean opioid dose just smooths out the rates, which is not as helpful. Is it possible to understand how many of our patients are impacted with large changes of daily MME in small periods of time?

David Kelly responded that he has started looking at individual patient level data, and graphing the 14 day average MME of time. In some cases, it is possible to identify a deliberate reduction in dose and it is also easy to identify an abrupt stop. Everything in between is difficult to interpret. The DHS team will continue to work on this, with the OPWG input, in order to determine whether we can identify the concerning, abrupt changes. Another member asked Kelly if he could create a graph showing change over time for each provider. Kelly answered that it is difficult, but possible if we can agree on the process for assigning a patient to a provider (if they are receiving opioid therapy from more than one provider over the course of the year). Members expressed support for looking at change over time by provider.

## Provider disenrollment standards: Introduction

Rinn reviewed the OPIP statute, and the requirement for the work group to recommended disenrollment standards for providers. A member asked whether any provider groups are exempted from this part of the program. Rinn reviewed the process for exceptions, which are generally applied at the patient-level. The OPIP statute does not explicitly exempt any provider types from the project.

The key message shared during the meeting is that the disenrollment standards are distinct from the sentinel measures and quality improvement thresholds. It is not necessarily an extension of the QI program, unless the work group determines that the appropriate course of action. A member urged the work group to think of this part of the program as an opportunity to define new definitions and a new thought process for identifying unsafe opioid prescribing behaviors. Discussed ensued about the need for ongoing patterns of unsafe prescribing behavior, and the importance of considering what happens to the patients of disenrolled providers. This is an opportunity for the work group to develop incentives for slow, cautious changes to opioids prescribing, or—in other words—a guardrail against some of the unintended consequences of the work.

Meeting adjourned.