Opioid Prescribing Work Group

Minutes — June 17, 2021
12:00 pm –2:00 pm
WebEx Video Event

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

Members absent: Chris Eaton, Rebekah Forrest, Matthew Lewis

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

Welcome and introductions

Julie Cunningham called the meeting to order and welcomed members. Opioid Prescribing Work Group (OPWG) members introduced themselves. Members reviewed the May OPWG draft meeting minutes. Rebekah Forrest was incorrectly identified as absent from the meeting (she arrived late). Thomas moved to approve the minutes with the attendance record fixed; Haake seconded the motion and the minutes were approved.

State agency updates

Ellie Garrett shared that two changes to the OPIP statute were approved during the legislative session. First, the two consumer seats for patients who experience chronic pain are now voting positions and the Minnesota Department of Health representative is now officially included in the statute. The second change relates to distribution of the DHS opioid prescribing reports. Beginning with the 2021 reports (issued in 2022), DHS now has the authority to send a provider group all of the reports of clinicians affiliated with their practice, regardless of the clinician's quality improvement status.

Garrett also shared that the Institute for Clinical Systems Improvement (ICSI) will close at the end of 2021. ICSI is currently contracted to provide technical assistance and quality improvement expertise for the OPIP QI project. DHS will secure ongoing support for the project and the QI participants for 2022.

Opportunity for public comment

No public comment was provided.

Disenrollment domains

Rinn provided an overview of the requirement to define disenrollment standards, and the role of the DHS Office of Inspector General – SIRS unit in investigations and sanctions. A copy of her slides is available upon request. Discussion of two of the domains previously identified by the OPWG followed.

Abrupt taper or cessation of opioid therapy

The objective of the discussion was to define criteria that can be used to evaluate whether a provider is engaged in unsafe tapering practices. In other words, if OIG receives a complaint that a provider is abruptly tapering patients off of long-term opioid therapy, what criteria should be used to determine if a provider has fallen below the standard of care? Rinn presented two recent articles that analyzed taper rates in specific populations, and presented an overview of taper rates provided in the medical literature and state and national guidelines. The articles presented are listed below:

1. Mark TL and Parish W. Opioid medication discontinuation and risk of adverse opioid-related health care events. *Journal of Substance Abuse Treatment.* 2019.

2. Neprash HT, Gaye M, Barnett ML. Abrupt discontinuation of long-term opioid therapy among Medicare beneficiaries, 2012-2017. *Journal of General Internal Medicine.* 2021: 36;1576-1583.

The group briefly discussed the two articles. Several members noted that the timeframe of the studies, which in general occurred during a period when faster taper speed were recommended in guidance.

Rinn then presented an infographic that addressed components the group may consider in defining an abrupt taper: dose, duration, speed, documentation of the risk, referrals and follow-up, and morbidity and mortality following a taper. She clarified that there are elements that DHS can identify in administrative claims data (dose, duration, and possible speed), but other elements would have be assessed in a chart review. Discussion followed about looking at doses greater than 200 MME per day to define an abrupt taper. Members were generally in consensus that dose considerations are a gradation, and other factors inform whether a taper from a given dose for an individual has the potential to cause harm. It is very important that any review of a dangerous taper also examines a number of variables, including a patient's comorbidities. Members discussed whether the definition could use dose, duration and speed of the taper as exclusionary criteria. For example, a taper in which the dose is less than 50 MME/day, the patient has received COAT for less than 3 months and the taper is less than 2 or 3 months long would not be considered a dangerous taper. A member commented that the risk of mortality in an abrupt taper is important (and may be more important than actual mortality in terms of identifying whether the provider knowingly put the patient at risk for harm). The major elements in determining risk of mortality is a known opioid use disorder and a previous non-fatal overdose. The presence of an active mental health diagnosis should also be a factor, but does not convey the same risk as the major elements identified. Other factors may include no follow-up with the tapering clinician or physician, subsequent encounters with an Emergency Department, and other opioid-related encounters.

The discussion then turned to questions about how DHS will operationalize investigating abrupt taper criteria. DHS confirmed that the criteria will not be used to create a population-based measure to identify providers who may be tapering opioid therapy. The criteria will be used by the OIG as part of their investigation of a clinician. The work group briefly discussed how OIG referrals occur. LaBrie commented that most referrals do not originate from patients, and that the OIG uses Medicaid data to identify concerning practices. Most investigations start internally, often with policy staff referring a case to OIG. She also told the members that providers are often unaware that a referral has been made or that an investigation occurs, unless the OIG-SIRS unit identifies fraud, waste or abuse. LaBrie commented that if the OPWG identifies abrupt cessation or tapers as an action that could be sanctioned, then the OIG-SIRS unit needs to know what that constitutes and the factors that should be included in an investigation. Members expressed concern about sanctioning a clinician

based on one instance of an abrupt taper, given the consequences. However, there was pushback that the consequences to that one patient who is cut off can be just as significant or more so.

Some confusion remained about how the disenrollment standards will be operationalized, and how cases will get referred to OIG. Members requested additional information and/or data to understand the current scope of the problem. DHS staff confirmed that a taper data analysis is in the works, and will include some of the elements that were discussed today.

A member asked how this work and these standards will be communicated to the medical community. DHS responded that there will be an opportunity for formal input. DHS will codify the standards, either by changing the OPIP statute or developing an administrative rule. Both routes present an opportunity for formal public engagement. In addition, DHS will disseminate the information through its typical communications channels and through external partners.

Continued opioid prescribing after contraindication

Rinn presented a case study extracted from a Veterans Health Administration Office of Inspector General investigation of a VA physician. The case study examined the care provided to a patient managing pain with opioid therapy. This was a complex patient with multiple comorbidities, but who continued to receive opioid therapy after multiple non-fatal overdoses.

Discussion followed with multiple members acknowledging that the case study describes a very common scenario, and is an example of inappropriate care. Members cited issues in the case such as the family reaching out for help as a major red flag, and the established OUD with prior non-fatal overdoses. A member commented that the true litmus test is how providers respond when they are confronted about their practice, and those unwilling to change their behavior should be addressed.

Institute for Clinical Systems Improvement (ICSI): DHS quality improvement project

Audrey Hansen from ICSI provided an overview of the quality improvement technical assistance work. A copy of her slides are available upon request. She reviewed how ICSI will support the two QI goals: 1) improve opioid prescribing practices across the state of MN, especially those providers identified by DHS; and 2) improve the safe and effective management of individuals who receive chronic opioid treatment for pain. The components of each goal are identified in the slide presentation.

A brief discussion ensued about the chronic pain human centered design work. Hansen clarified that this work is focused on learning about what people—both patients and providers—are most resistant to in terms of changing their approach to opioid therapy, what they most need to be successful, and how the process can improve. From a prescriber perspective, it is about understanding why clinicians continue to prescribe outside the guidance despite harm or risk of harm.

Members briefly discussed the outreach and recruitment process for the chronic pain patient cohort, and Hansen requested input if any of the OPWG members knew someone well suited and available to be on either cohort.

Meeting adjourned.