Opioid Prescribing Work Group

Minutes — November 23, 2015
12:30 – 3:30 p.m.
444 Lafayette Building, St. Paul

Members present: Julie Cunningham, Chris Eaton, Tiffany Elton, Rebecca Forrest, Ifeyinwa Nneka Igwe, Chris Johnson, Ernest Lampe (non-voting), Matthew Lewis, Pete Marshall, Murray McAllister, Richard Nadeau, Mary Beth Reinke (non-voting), Charles Reznikoff, Jeff Schiff (non-voting), Matthew St. George, Alvaro Sanchez, Lindsey Thomas

Members absent: None

State employees:

- Department of Human Services: Commissioner Lucinda Jessen, Cambray Crozier, Charity Densinger, Sara Drake, Ellie Garrett, Tara Holt, Melanie LaBrie, Sarah Linville, Sarah Rinn
- Department of Health: Dana Farley, Mark Kinde
- Department of Labor & Industry: Lisa Wichterman
- Board of Nursing: July Sabo

Guests: Adam Fairbanks (Valhalla Place), Tom Freeman (Faegre Baker Daniels), Cara Geffert (HealthPartners), Charles Hilger (Valhalla Place), Juliana Milhofer (Minnesota Medical Association), Jeremy Olson (Star Tribune)

I. Welcome and context for the OPWG's work

Jeff Schiff welcomed everyone to the first OPWG meeting, and brief introductions were made around the room. More detailed introductions of OPWG members were interspersed throughout the meeting. Commissioner Jesson addressed the meeting, welcoming the work group and guests. She stressed the importance of addressing the prescription opioid crisis and thanked members for giving their time to this issue.

Schiff framed the OPWG's work in the context of how we think about pain within health care. Together we should be working to reduce suffering, and within that context, address opioid prescribing. The prescription opioid crisis is not one that state government can solve alone, and to that end Schiff and colleagues sought and obtained support for the Opioid Prescribing Improvement Program (of which this work group is a pivotal part) from health plans, health systems and health care providers.

Highlights of Schiff's presentation include:

- The US comprises just 4.6 percent of the world's population, yet consumes 80 percent of the world's prescription opioids.
- While Minnesota is faring better than most other states in terms of the prescription opioid crisis, there are harrowing disparities within the Native American population and to a lesser degree among non-Hispanic white Minnesotans.
- DHS' data show that the population of new, chronic opioid users is large and growing. Depending on the definition of new, chronic user, the number of such individuals is 5,000 to 6,000 people a year. Eighty percent of new, chronic users have a recent history of behavioral health problems or chemical dependence or both.

Members discussed the large number of new chronic opioid users and disparities within the Native American population. In response to a question, Garrett clarified that DHS cannot tell what diagnoses are most prevalent among opioid claims. Pharmacy claims do not contain diagnostic information. To link a patient's particular opioid claim to a particular diagnosis would require a chart review.

Tara Holt, who coordinates the state's substance abuse strategy, reported on other state activities relevant to the OPWG's work. In 2014 Minnesota was one of six states selected to participate in a National Governors Association-sponsored policy academy concerning prescription drug abuse. The academy led to the formation of a collaboration across state government called the State Opioid Oversight Project (SOOP). SOOP members comprise representatives of the departments of Human Services, Health, Education, Public Safety, Labor & Industry and Corrections, and the boards of Medical Practice, Nursing, Pharmacy, Dentistry, Veterinary Medicine and Podiatry.

The SOOP is focused on seven targeted focus areas:

- Neonatal abstinence syndrome
- Medication assisted treatment
- Opioid prescribing
- Prescription monitoring program
- Increasing access to naloxone
- Prevention
- Increasing prescription take-back opportunities

In response to legislation passed in 2015, the state is implementing several of these strategies. The state is building a program to provide integrated care to pregnant women at risk of delivering a low-birth-weight baby or a baby who has been exposed to opioids in utero. The state is also implementing Steve's law, designed to improve access to naloxone and distributing naloxone to emergency medical services providers via a one-time appropriation.

In August state and federal officials collaborated on a statewide summit called "Pain. Pill. Problem." Over 1,000 people attended the event, which was at Northrop Auditorium at the University of Minnesota. Several community leaders presented at the event, including some members of this work group.

Ellie Garrett, who is currently serving as the OPWG's primary staff support, summarized the legislation that authorizes the OPIP and calls for the OPWG's creation (Minn. Stat. § 246B.0638). The OPIP will be a comprehensive project to improve opioid prescribing that is community-driven, and the community is represented by the OPWG. Specifically, the OPWG is charged with recommending:

- Common protocols to treat:
    - Acute pain (0 – 4 days)
    - Post-acute (up to 45 days)
    - Chronic pain (> 45 days)
- Sentinel quality improvement measures for each domain
- Consistent messages for prescribers to give to patients
- Criteria for identifying Minnesota Health Care Program providers that should undertake quality improvement
- Criteria for terminating providers from MHCP whose prescribing practices are consistently and extremely outside of community norms

Garrett clarified that the OPIP does not apply to hospice patients or to treating cancer-caused pain. She shared a proposed work plan (attachment 1), that will likely be revised and become more detailed over time. While the OPWG is developing its recommendations, DHS will be working internally on the data reporting infrastructure that will be needed to implement the OPIP.

Schiff noted that OPIP's quality improvement processes will be confidential—names of providers and their respective institutions will not be made public during the quality improvement phase. A member cautioned about the disruption patients face whenever a provider is terminated. Schiff stressed that DHS hopes that no providers would need to be terminated because of outlying opioid prescribing practices. Improvement should ensue from clearer community standards for opioid prescribing and consistent quality measurement.

Members discussed briefly various definitions of acute pain, including pain lasting the first X days from onset of painful condition or injury,

II. Opioids for Acute Pain

Garrett suggested that the work group consider endorsing or refining existing prescribing protocols rather than creating guidance from scratch. To that end, she shared three prescribing protocols that address treatments for acute pain: Washington state's new guideline on prescribing opioids for pain (see Parts I, II and III on pages 9 – 31); ICSI's protocol on acute pain assessment and opioid prescribing; and recommendations from DHS' Emergency Department Work Group (available from OPWG staff). She invited members to submit other guidance documents from their health systems or professional societies to inform discussions around acute pain.

Though each of these documents vary in specifics, they have in common a number of domains:

- Assess and document function
- Assess and document pain
- Assess physical health contraindications/risks
- Assess mental health and substance use contraindications, including family history
- Consider take-home naloxone
- Avoid concomitant use of benzodiazepines and other concerning drugs
- Use lowest dose and duration
- Specific guidance regarding type of drug (short/long acting, IM, IV)

- Patient and family education about pain management, risks, benefits, reasonable expectations, safekeeping
- Check PMP
- Considerations regarding acute pain related/unrelated to concomitant chronic pain
- Consider multi-modal, non-opioid treatments as alternatives or adjuncts to opioids
- Provider/site-specific considerations
    - Dental
    - Emergency
    - Surgical

No public comments were offered.

Discussion among the members ensued. One member stressed the importance of access to addiction treatment, even though the OPIP's emphasis is on prevention. Another acknowledged the large portion of medical board reviews pertaining to prescribing practices. When patient harm occurs, there are licensure consequences and a system in place to protect the public.

One member suggested that when the OPWG's discussions turn to chronic pain, the group will have to address nuances of treating cancer patients, even though cancer-related pain is outside the OPIP's scope. Sometimes cancer patients are still receiving pain medications begun during cancer treatment even after their cancer has gone into remission.

Another member observed that all too often what gets labeled by a patient or provider as acute pain is neither acute nor even pain. Other members agreed that diagnostic accuracy is critical.

A member suggested including a list of conditions, like migraine and uncomplicated neck and back pain where opioids are known to be ineffective. Those diagnostic exclusions should be contained in the protocol. Garrett acknowledged that ICSI's guidance did address those exclusions, so the summary grid of domains being discussed should be expanded.

Members also discussed the 4-day duration in statute pertaining to acute pain. In contrast, Washington combines the acute and post-acute period in a single protocol.

After the break, Schiff opened the floor up again for public comment, but no comments were offered. Member discussion continued.

A member observed that risks of becoming a chronic user should be acknowledged when considering whether to initiate opioid therapy. People with low health literacy and pre-existing mental health conditions and/or pre-existing chemical dependency are at higher risk of chronically using opioids.

Another observed that ICD-10's approach to severity indexing might help to better segment patients who need or do not need opioid treatment. Schiff expressed concerns with the tendency for diagnosis creep, which is a factor in billing; one hopes that it will not be a factor in opioid prescribing.

One member noted the importance of considering current incentive structures for clinicians—including incentives around lowering pain scores rather than treating pain appropriately. Other members agreed.

A member suggested that the group consider noting that opioids should not be considered as a first-line therapy. Another suggested that opioids should not be initiated without an endpoint and exit strategy,

both of which require a very clear diagnostic assessment of mental health, pain generators and substance use. He shared an anecdote about a young trauma patient who was struggling with mental health issues. Even in the emergency department, patients should always be screened for mental health or substance abuse, just as all patients who receive antibiotics are asked about allergies. Another member observed that ICSI's ABCDPQRS protocol covers what providers need to know, so long as it is always used. Another member agreed with the importance of assessing mental and chemical health history even in trauma patients, given the propensity of some patients to self-injure in order to obtain opioids.

One member noted that checking the PMP goes a long way to identify drug-seeking behaviors, but access to the PMP is too restricted. Even when part of the treating team, pharmacists cannot access the PMP. They can do so only if they are filling the prescription. Some providers have addressed this access problem by requiring patients to consent to checking the PMP as part of admission. A member noted, though, that many drug-seekers will use multiple names to obtain medications, thus thwarting the PMP. A robust database alone in insufficient; provider education about drug seeking is also important.

One member reported another PMP problem, which concerns medication-assisted treatment for addiction. While suboxone dispensed at a pharmacy will be reported to the PMP, medications dispensed at a methadone clinic are not. In this regard, Minnesota's privacy laws impede patient care. Similarly, Title 42 prohibits law enforcement personnel from monitory a drug treatment facility, even when criminal activity is suspected.

Schiff queried whether a requirement to check the PMP for every opioid prescription is reasonable. Is it necessary to check the PMP when treating a child with a long-bone fracture at a pediatric emergency room when there is no abuse suspected? It is important to not over-burden providers. Similarly, should a requirement to screen for mental and chemical health history be universal?

Members discussed varying perspectives on whether a naloxone prescription should be standard when initiating opioids. Some members suggested that patients whose personal, family or living circumstances put them at heightened risk of overdose or diversion should receive naloxone; others suggested that access to naloxone should be universal for all opioid recipients. Another member queried the relative priority for naloxone as a rescue treatment in relation to addiction prevention and treatment.

Members briefly discussed the importance of quality measurement and for providers to be able to see where their own prescribing patterns fall in relation to their peers. One member stressed the importance of normalizing the data with regard to patient risk adjustment, regional differences, provider types and other variables. Other members noted that other large systems are beginning to embracing measurement on prescribing patterns, such as the Veterans Administration and Medicare.

Schiff stated that the domains document would be revised and brought back for consideration at the December meeting.

III. Other business

Garrett distributed reimbursement forms to the members and asked them to watch for an email regarding scheduling for 2016 meetings. Future meetings will be supported by webcasts (for non-members) and full, two-way audio/visual connections for members.

The meeting was adjourned at approximately 3:30.

Attachment 1

Opioid Prescribing Work Group
Work Plan