Opioid Prescribing Work Group

Minutes — May 18, 2017
noon – 3:00 p.m.
444 Lafayette Building, St. Paul

Members present: Julie Cunningham, Tiffany Elton (remotely), Dana Farley (non-voting), Ifeyinwa Nneka Igwe (remotely), Chris Johnson, Ernest Lampe (non-voting), Matthew Lewis (remotely), Pete Marshall, Murray McAllister (remotely), Richard Nadeau, Charles Reznikoff, Jeff Schiff (non-voting), Lindsey Thomas

Members absent: Chris Eaton, Rebekah Forrest

DHS employees: Charity Densinger, Barbara Frank, Ellie Garrett, Dave Hoang, Tara Holt, Chad Hope, David Kelly, Monica Patrin, Brian Zirbes (remotely)

Guests: Jim Cook (Mercer), Kate Erickson (MDH), Juliana Milhofer (MMA), Chuck Sawyer (Minnesota Chiropractic Association), Kelley Waara-Wolleat (Purdue), Lisa Wichterman (DLI)

Welcome and Introductions

Chris Johnson called the meeting to order. Johnson welcomed members and guests, and introductions were made around the room.

DHS Updates

Jeff Schiff provided a brief update on the State Targeted Response (STR) to the Opioid Crisis grants. DHS is in the process of reviewing the STR proposals, and awardees will likely be announced in early June. Sarah Rinn announced that DHS received four proposals in response to the opioid prescribing marketing campaign RFP. A firm has been selected, and DHS is preparing for contact negotiations.

Charlie Reznikoff informed work group members about an opportunity to develop a 4-hour education session about opioid prescribing, with CME credits. The presentation is hosted by ACP and MMA, with support from the Rummler Foundation. Reznikoff requested that group members consider whether they are interested in presenting during the session.

Approval of Minutes

Members unanimously approved the March meeting minutes.

Opportunity for Public Comment

Chuck Sawyer (Minnesota Chiropractic Association) thanked the work group for the opportunity to provide comments on the Post-Acute Pain Prescribing Recommendations. Sawyer review the public comments submitted by the Minnesota Chiropractic Association and Northwestern Health Sciences University. A copy of the public comments is available upon request at dhs.opioid@state.mn.us.

Rinn reviewed meeting logistics. A copy of the presentation is available by request at dhs.opioid@state.mn.us. Rinn also updated the work group on the nomination process for the Health Plan Medical Director and Law Enforcement Representative members of the work group. The nominations are currently under review by the DHS Commissioner.

Post-Acute Pain Public Comment Review

Members received the complete set of public comments prior to the May 18 OPWG meeting. Specific comments were flagged for discussion with the work group.

The first public comment addressed confusion about the end of the post-acute pain period (45 days) and the onset of chronic pain (90 days). Rinn reviewed the pain period definitions included in the OPIP authorizing statute. Discussion ensued about the importance of distinguishing between specific intervals of pain (i.e. acute, chronic), and timeframes related to opioid exposure. Members also commented on related MDH and DLI rules that explicitly allow treatment of pain up to 90 days with controlled substances. A member also clarified that intractable pain does not equate to chronic pain, and may be experienced by patients in any of the pain phases (acute, post-acute or chronic).

The next public comment suggested including additional guidance about treating individuals whose occupation is affected by opioid use. The commenter suggested citing the Joint Statement on the Impact of Health Conditions and Medication Use on the Operation of Vehicles in the recommendation. Members agreed to include a reference to the statement in the recommendation. The commenter also suggested including a unique recommendation for health care providers with opioid misuse or emerging abuse, e.g., referral to the Health Professional Services Program, given their unique access to opioids. Members agreed that a referral to HPSP in the post-acute period is inappropriate, however it may be beneficial to include a general statement about impairment and opioid use in this time period. Discussion then turned to addiction treatment and patient occupations. A brief discussion ensued about addiction treatment among city transportation providers.

Members discussed the comment that chiropractic, acupuncture providers and message therapists should be included in a clinician's referral network. Discussion ensued about the current state of the evidence about these treatments as pain management modalities. Members considered looking at the medical literature to support including specific treatments in the recommendation. Ellie Garrett provided a brief overview of the work done by HSAC on acupuncture, including the recommendation to cover acupuncture in the MHCPs. A member commented that specific recommendations about non-opioid and non-pharmacologic therapies are outside the scope of this work group. Members agreed that other guidance documents—such as the ICSI Pain Health Care Guideline—address this issue appropriately.

Discussion then turned to the public comments received about the dose and duration recommendations. Members discussed two sources in support of the OPWG dose and duration limit: 1) the recent MMWR article about characteristics of initial opioid prescriptions and the likelihood of continued use, and 2) the 2016 article by Deyo et al published in the Journal of General Internal Medicine. Both studies found that risk of long-term opioid use increased when the cumulative dose of the initial prescription was in the 400-800 MME range. Members agreed that these studies support the OPWG dose and duration recommendation. Members agreed that no change should be made to the recommendation.

Finally, the work group members discussed various comments made about the Post-Acute Pain Prescribing and Assessment Chart. Members agreed to add a column for the acute pain phase, and revise the title and narrative accordingly. Members discussed the suggestion to recommend chemical dependency (CD) screenings at every refill during the post-acute pain period. Members reached consensus that the recommendation about chemical dependency screening should not change. Completing a chemical dependency screening at every refill is overly burdensome, and may not be clinically appropriate for all patients in this timeframe. Members agreed that clinicians must know their patient's chemical use history in order to appropriately treat the patient, but when nociceptive pain is expected it is not necessary to complete a CD screening.

Other Updates

Johnson briefly reviewed the results from the SPACE (Strategies for Prescribing Analgesics Comparative Effectiveness) Trial conducted at the Veterans Administration. Results after one year show no distinction between the opioid therapy and non-opioid study arms, but the opioid treatment arm had more treatment-related complications.

Acute and Post-Acute Pain Prescribing Data Analysis Review

Rinn introduced the acute and post-acute pain prescribing data analysis. A general description of the approach and the data presented is available by request at dhs.opioid@state.mn.us. The purpose of the analysis was threefold: 1) to apply the specialty grouping methodology to the Medicaid administrative claims data; 2) to report acute and post-acute pain prescribing behavior by specialty; and 3) to test the morphine milligram equivalence conversion methodology within the DHS database.

Application of the specialty grouping methodology worked reasonably well. Additional work is required to clean up some of the data, and to address prescribers who do not have a taxonomy code, have an obviously outdated code (i.e., Student), or are using a code that is too general for the purpose of peer comparison.

DHS staff reviewed the methodology used to identify index opioid prescriptions for previously opioid-naïve enrollees. Opioid prescriptions were assigned to the prescriber listed on the pharmacy claim. Schiff clarified that 9 months of data was included in the analysis, but the overall rates provided are annualized for the sake of comparison with rates calculated by other groups. The data analysis found 40 prescriptions per 100 member years, which is slightly lower (and calculated differently) than the CDC's rate of prescribing for Minnesota. This analysis found 147,000 naïve opioid prescriptions.

DHS staff presented the index opioid prescription data for the following specialties: Dentists-General, Emergency Medicine, Family Medicine, OB/GYN, Other PA-APRN, Orthopedic Surgery, Pediatrics and Surgery. The prescribing rate (index fills per distinct number of Medicaid recipients) was calculated for each opioid prescriber. Prescribers were then organized into quartiles by prescribing rate, by specialty. In each quartile, the following data was provided: number of index prescriptions; distinct number of recipients; average number of prescriptions per provider; total number of tablets prescribed; average number of tablets per prescription; and range of tablets prescribed per prescription.

Discussion ensued about the variation in the number of index prescriptions prescribed per quartile. The variation was consistent across the specialties presented, including Emergency Medicine. Members discussed

the significance of this finding, given that Emergency Medicine providers are more likely to have a comparable patient mix than other specialists. Members also discussed the findings that the prescribers in the highest quartile (highest prescribing rates) consistently saw fewer distinct Medicaid patients than those in lower quartiles.

Discussion then turned to prescribing behavior and the heterogeneity of practice among providers in a given specialty. Work group members asked DHS whether it is necessary or possible to explore this for the sake of data reporting. DHS staff responded that the administrative burden of linking a prescription to a procedure code is prohibitive for the analysis and subsequent data reporting, given the number of prescriptions and providers included. A brief discussion ensued about organizing providers by other factors, such as MME.

Members briefly discussed other efforts within specialist societies to examine opioid prescribing behavior. Two members commented specifically on efforts underway within the orthopedic practices. A recent effort among the orthopedic department at a large health system has successfully lowered the daily MME and number of tablets in the initial post-operative prescription. However, the MME and number of tablet limits still far exceed the OPWG recommendations. A member commented that it may be necessary for some groups to have an incremental approach to reducing dosage and duration of therapy.

Discussion then turn to the post-acute pain prescribing analysis. Rinn presented overall data on the number of prescriptions written in the following time frames after an index fill: 0-4 days, 5-14 days, 15-21 days, 22-28 days and 29-45 days. The time periods used in the analysis are related to the time frames identified in the OPWG Post-Acute Pain Prescribing and Assessment Guide. Additional analysis needs to be completed for this pain phase, so a general discussion of the findings ensued. Members discussed the following issues related to the data analysis:

- Variation in the number of days within each time interval. A recommendation was made to correct the data by the number of days in the interval, or standardize the number of days within each category.
- There is a fairly even distribution of refills over the 45 day post-acute pain period. Members commented that they expected a gap in prescribing early in the post-acute period.
- Initial analysis suggests that prescribing behavior among clinicians in the post-acute pain period does not differ significantly from observed behavior for the index fill. High-volume prescribers identified in the index fill analysis continue to prescribe more opioids. A brief discussion ensued about the effects of different drivers of opioid prescribing behavior, including provider behavior and patient characteristics, at different times within the pain phases.

Discussion then turned to the chronic pain prescribing domains. Rinn presented examples of chronic opioid prescribing measures under development in Washington State. The domains of interest include dose, duration, total MME, and concomitant use. Schiff reminded members that the COAT measures should focus on safety, harm reduction, and safe management of chronic opioid users. Members also commented that there should be a measure of rates of chronic use, in order to determine whether the strategy is effective. Members provided examples of other drugs/drug classes to potentially include in the concomitant prescribing analysis: carisoprodol, sedative/hypnotics, Ambien, antidepressants, and other mental illness prescriptions.

Meeting adjourned.