# Opioid Prescribing Work Group

Minutes — September 21, 2017
noon – 3:00 p.m.
444 Lafayette Building, St. Paul

**Members present:** Julie Cunningham, Chris Eaton, Tiffany Elton, Dana Farley (non-voting), Rebekah Forrest, Ifeyinwa Nneka Igwe (remotely), Brad Johnson, Chris Johnson, Ernest Lampe, , Matthew Lewis, Pete Marshall, Murray McAllister, Richard Nadeau, Charlie Reznikoff, Jeff Schiff (non-voting), Charles Strack

**Members absent:** Lindsey Thomas

**DHS employees:** Charity Densinger, Ellie Garrett, Tara Holt

**Guests:** Kira Bork (Weber), Jim Cook (Mercer), Jocelyn Good (Pfizer Medical Affairs), Juliana Milhofer (MMA), Krista Panosian (BDSI), Ann Tart (DLI), Trudy Ujdur (Sanford), Kelley Waara-Wolleat (Purdue), Lisa Wichterman (DLI), Kaylan Wilson (Pfizer Medical Affairs)

## 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 updates on opioid-related efforts within state government. First, Tara Holt accepted a new position within DHS focused on integrating opioid-related efforts across the department's administrations. Second, the first grantee meting for the State Targeted Response (STR) to the Opioid Crisis was held. In addition, DHS received another federal grant for expanding Medication Assisted Treatment (MAT). The new grant is $6 million over 3 years. Third, the Governor and Lt. Governor are going to develop a statewide strategic plan to address the opioid crisis. This will allow state agencies currently involved to accelerate existing efforts, and to enhance coordination across departments.

## Approval of Minutes and Opportunity for Public Comment

Members unanimously approved the August meeting minutes.

No public comments were offered.

## Other Updates

A member asked whether we need a statement that addresses the relationship between the Opioid Prescribing Improvement Program—guidelines, measures, quality improvement program—and ICSI's opioid-related work. A brief discussion ensued about the relationship between the two efforts, and confusion in the community about which guidance to follow. Schiff shared that DHS and ICSI staff are scheduled to meet in

early October to discuss our respective work and opportunity for alignment. Schiff shared two themes related to how we approach the relationship with ICSI. First, DHS respects ICSI's work and it has informed the work completed by the OPWG. Second, DHS' expectation is adherence to the measures and guidelines within Medicaid. DHS supports using consistent measures for all Minnesotans across providers and plans, and creating consistency in reporting for quality improvement.

**A motion was made to develop a brief statement to accompany the guidelines that addresses the collaborative nature with ICSI, and clarify the similarities and differences between the respective guidelines. The motion was seconded, and unanimously passed.**

Other members provided additional updates. Dana Farley updated the work group on the MDH Opioid Prevention Pilot. The overall goal of the grant program is to reduce opioid use through the use of controlled substance care teams. The RFP period for the technical assistance provider just closed, and MDH will determine who will receive the grant next Friday. Sarah Rinn told the group that the OPIP 2017 legislative report was submitted, approved, and will be sent to the legislature.

Rinn reviewed meeting logistics. A copy of the presentation is available by request to dhs.opioid@state.mn.us.

A brief discussion ensued about extending the term of the Opioid Prescribing Work Group. The tentative plan is to reconvene the work group members in microbursts in autumn 2018 and then again at a later date. The purpose of reconvening the group is to seek input from members on the quality improvement process, and the standards for disenrollment from the MHCP. DHS would like input on those two factors once the prescriber reports have been released. Members expressed interest in extending the work group.

## Opioid Dashboard Introduction

Dana Farley introduced the MDH Opioid Dashboard to the work group. The dashboard is available at http://www.health.state.mn.us/divs/healthimprovement/opioid-dashboard/. Farley briefly reviewed the process for signing up and receiving updates. He then walked through the categories provided on the main page, and explained how the data, resources, references, and narrative are organized and presented within each category. Members asked about various data points, and he reviewed how to find and access that data. MDH is also open to suggestions about the current content, or additional data to add. Members were very excited about using this a resource. A member asked whether ambulance treated overdose data is reflected in any of the existing data. Farley informed the group that MDH and the 8 regional Emergency Medical Service (EMS) districts are working together on the data. MDH just gained access to the EMS registry, and will spend time reviewing and cleaning up the data. The EMS registry does not include law enforcement administrated naloxone, but that has been identified as important data to collect.

A member asked whether the dashboard has data on the number of nonfatal overdoses on tribal reservations. Farley answered that Indian Health Services and the VA are not part of MDH's All Payer Claims Database, so MDH does not access to that data. Another member asked how often the dashboard will be updated. The refresh cycle is dependent upon the measure. Another member asked whether additional items can be added, and suggested adding access to Medication Assisted Treatment given the need to improve access. Charlie Reznikoff volunteered to talk offline about how best to gather MAT data.

## Opioid Prescribing Report

Rinn briefly reviewed the statutory authority for the data collection and reporting of individual prescriber's opioid prescribing patterns. She then explained that the report will most likely be sent as a pdf document, accompanied by a cover letter explaining the report and its use, via email. The work group members reviewed the draft opioid prescribing report provided in the meeting folder. A member suggested simplifying the language ever further, and providing very simple definitions of the terms used. Another member asked whether there will be training on how to interpret the report. Provider training has not yet been considered, but there are likely existing resources for those efforts within DHS. A brief discussion ensued about whether to include standard deviations, data on variation, or distribution curves for various measures. DHS will take this into consideration. Another member suggested adding baseline data over time. Members briefly discussed the frequency of reporting and goals related to specific measures.

## Index Opioid Prescribing Measures: Rate of prescribing >100 MME or >200 MME, by specialty

Rinn reviewed the specifications for the measure, and the method used to organize the quartiles. The work group then reviewed the analysis and discussed the findings. A member suggested displaying the truncated quartiles differently than Quartile 3 and 4. Discussion ensued about the significant number of providers prescribing over the recommended limits, and how to best accomplish behavior change. Members discussed the pros and cons of a legislatively mandated prescribing limit for the index opioid prescription versus using the quality improvement program—and peer pressure—as a motivator. Several members expressed support for using the data and the quality improvement review—along with other efforts at ICSI and within health systems—to guide prescriber behavior change versus a mandated dose limit. Another member commented that employer support and guidance on how to change behavior must accompany the prescribing reports in order to maximize the effect. A brief discussion ensued about to help providers move from goals to action. A member commented that most providers did not need significant help in his health system when a similar opioid-related effort was put in place, but there were some providers who needed significant help with quality improvement processes.

## Initial Opioid Prescribing Episode Measure: Rate of prescribing >700 cumulative MME, by specialty

Rinn reviewed the specifications for the measure, and the method used to organize the quartiles. The work group then reviewed the analysis and discussed the findings. A member commented that it may be difficult for health plans or health systems to replicate the cumulative MME data. Another member commented that the analysis includes one extra conversion step, and DHS commented it will be willing to assist providers interested in being able to run this measure. Members discussed the novel nature of this measure, and members were reaching consensus that the cut-off between the third and fourth quartiles will be an appropriate threshold for the QI review.

## Chronic Pain Prescribing Measures and Data Analysis

Rinn reviewed the set of chronic pain prescribing domains recommended by the group—frequency of prescribing COAT, high-dose COAT, concomitant prescribing, and multiple providers—and explained that that analysis was completed for the first three domains. She also reviewed a change in approach to the chronic prescribing measures. Initially, the proposed measures used the definition of chronic use that is consistent with the New Chronic Use measure (a 45 days' supply over 90 days). However, in order to use that definition of chronic use and apply it across the measurement year, it would be necessary to develop a patient attribution algorithm. DHS staff reviewed other existing measures of chronic opioid prescribing intended to be reported at the prescriber level. In general, the measures included in the review used a longer days' supply across the measurement period. This approach makes the measure less precise, but it also is easier to run on a large scale. DHS staff considered both approaches, and decided to analyze the chronic pain prescribing domains using the easier measure approach. An addition analysis was completed with the more precise COAT definition, for comparison.

Rinn first presented the data from the analysis using COAT definition that is consistent with the New Chronic User measure: ≥ 45 days' supply over a 90 day supply and ≥ 60 days' supply over a 90 day period specifications. The 60 day supply parameter was included for comparison. If enrollees had at least one instance of a 45 day or 60 day supply over a 90 day period in the measurement year, the enrollee was counted once. Members discussed the two approaches to measuring chronic opioid use: a more precise, complicated measure requiring a patient attribution model, or a less precise measure that is easier to use in a large analysis. A member commented that his health system ended up looking at chronic prescribing using a simpler measure with less precision.

The work group members next reviewed the first chronic opioid prescribing measure data to be included in the prescriber reports. The first measure was the percent of enrollees prescribed at least 1 opioid Rx who received ≥ 60 or ≥ 90 day supply of opioids in the measurement year. A brief discussion ensued, and it was clarified that the overall "specialists" category excludes hospice and oncologist providers.

The second measure reviewed addressed high-dose COAT: > 50 MME/day and > 90 MME/day. Members commented on the consistency of the data across all four categories. This is likely explained by the high volume of prescribing within primary care, and its disproportionate effect on the overall rate of high-dose COAT.

The third measure reviewed was the concomitant opioid and sedative prescriptions. Discussion ensued about whether to just analyze concomitant prescribing with benzodiazepines, or with benzodiazepines and other sedative hypnotics. Members discussed the appropriateness of specific sedatives. The work group members agreed that the benzodiazepines are the most important drug class to analyze. DHS staff will assemble the list of other sedative-hypnotics included in the analysis, and share with the group for feedback offline.

DHS staff explained that the analysis for the last measure was not completed for this meeting. The data will be presented at the next meeting.

## Prescribing Recommendations

Rinn briefly reviewed the layout for the final set of opioid prescribing recommendations, and requested feedback on the organization of the document. DHS also requested feedback from the work group members on two final issues: limiting prescribing to 700 cumulative MME during the index opioid prescribing episode, and providing additional information about naloxone training. DHS presented language about naloxone education that directs the user to the MDH naloxone web site. The work group unanimously agreed to the change. Rinn then presented recommendation language to include about the 700 MME cumulative limit. Work group members unanimously agreed to add the recommendation to the post-acute pain prescribing recommendations. One member recommended adding an example of the approximate number of pills that represent 700 MME.

Meeting adjourned.