

Opioid Prescribing Work Group

Minutes — December 21, 2017

noon – 3:00 p.m.

444 Lafayette Building, St. Paul

Members present: Julie Cunningham (remotely), Chris Eaton, Tiffany Elton (remotely), Dana Farley (non-voting), Rebekah Forrest, Brad Johnson (remotely), Chris Johnson, Ernest Lampe (non-voting), Pete Marshall, Murray McAllister (remotely), Richard Nadeau, Mary Beth Reinke (non-voting), Charlie Reznikoff (remotely), Jeff Schiff (non-voting), Charles Strack, Lindsey Thomas

Members absent: Ifeyinwa Nneka Igwe, Matthew Lewis

DHS employees: Charity Densing, Ellie Garrett, Tara Holt, Sarah Rinn

Guests: Jim Cook (Mercer), Kate Erickson (MDH), Daniel Lightfoot (Minnesota Dental Association), Trudy Ujdur (Sanford), 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 number of updates on opioid-related activities in state government. First, he thanked the work group members who were able to attend the December 1 press conference at Abbott Northwestern. The announcement of the guidelines was successful, and it was significant to have so many of the OPWG members in attendance. DHS is accepting public comments on the guidelines through the end of December. Once the public comment period is over, DHS staff will aggregate the comments and share with the work group members. Comments have been submitted so far by individuals, providers, and organizations, including the Minnesota Medical Association. A member asked whether the Board of Medicine had submitted a comment. No comments have been received to date.

Second, Schiff informed the work group that he spoke about the OPIP at the Minnesota Hospital Association's board meeting, and the work was well received. Third, DHS and its partner organizations continue to implement the federal State Targeted Response (STR) grant. A notable update is that the CHI St. Gabriel's ECHO Hub did a trial run on November 30. Schiff encouraged members to speak with their colleagues about their willingness and readiness to treat OUD, and the presence of the ECHO program to assist with developing treatment programs.

Dana Farley commented on the briefing held with MDH Commissioner Ed Ehlinger about the prescribing recommendations. Discussion ensued about the reference to the Office of Medical Cannabis added to the draft

opioid prescribing guidance. Members agreed to revisit the section when the OPWG meets in 2018 and discusses comments received about the guidelines.

Approval of Minutes and Opportunity for Public Comment

Members unanimously approved the November meeting minutes.

No public comments were offered.

Statement on Other Opioid Prescribing Guidelines

DHS shared a draft statement about the relationship of the Minnesota Opioid Prescribing Guidelines to other existing prescribing guidelines. The work group members requested that DHS draft this statement at a previous OPWG meeting. Rinn will send the draft out as a word document for member review and comment.

Initial Opioid Prescribing Interval Measure: Quality Improvement Threshold

Members began their review of the initial opioid prescribing episode measure. This measure is the number of opioid prescriptions that either cross the 700 cumulative MME threshold or exceed 700 MME per the number of opioid prescriptions written in the initial opioid prescribing episode. The initial opioid prescribing episode is the timeframe beginning on the date of the index opioid prescription plus 45 days. Members reviewed the data, which was organized by quartile within each specialty group. Discussion ensued about the quality improvement threshold for this measure. Members discussed whether a minimum number of prescriptions is appropriate to require a provider to participate in the quality improvement process. No consensus was reached about whether this is appropriate. Members also discussed the fact that the current attention to post-operative prescribing within health systems is likely to reduce the number of providers who cross the 700 MME threshold in the post-acute pain period.

A brief discussion ensued about the ICSI and CEO Collaborative proposal to develop tiered dosage recommendations based on the expected acuity level of a given surgical procedure. This is a more elaborate approach to post-operative prescribing. Schiff commented that the ICSI approach is compatible with the OPIP recommendation of 200 MME. If a provider performs procedures associated with a higher level of acuity, then he or she should perform mental and chemical health screenings consistent with the OPWG recommendations. Discussion ensued about setting the threshold for quality improvement at no more than 15% of prescriptions written in this interval crossing or exceeding 700 cumulative MME with special cause variation options for surgical specialists.

A motion was made to set the threshold for quality improvement at no more than 15% of prescriptions written in this interval crossing or exceeding 700 cumulative MME with special cause variation options for surgical specialists. The motion was seconded, and passed unanimously.

COAT Data: Review and Quality Improvement Threshold Discussion

Rinn reviewed the analysis of COAT prescribing within the Minnesota Health Care Programs, including an analysis of the total number of COAT enrollees by provider group. A copy of the presentation is available at dhs.opioid@state.mn.us. Work groups members review the data for the four COAT measures:

1. Total number of enrollees prescribed at least 90 days of COAT
2. Percent of enrollees prescribed high-dose COAT (50 MME/day and 90 MME/day)
3. Percent of enrollees prescribed high-dose COAT and concurrent benzodiazepines; and
4. Proportion of enrollees prescribed COAT who received prescriptions from 4+ prescribers

Discussion ensued about the quality improvement thresholds for each measure. First, members discussed the frequency of prescribing COAT. The rate at which a provider prescribes COAT is highly dependent on their specialty and practice type. Members agreed that this data should be shared for informational purposes, and should not have a quality improvement threshold. Members acknowledged concerns about providers abruptly ending COAT among patients, or refusing to continue COAT therapy. The COAT measures and recommendation are about improving the quality of opioid prescribing. Cutting people off of long-term opioid therapy in an abrupt manner is not and should not be the outcome of these efforts.

Discussion turned to the second measure: enrollees prescribed high-dose COAT for at least 90 days. This measure is the number of enrollees prescribed ≥ 50 MME/day or ≥ 90 MME/day for at least 90 days during the measurement year. Members discussed the concentration of prescribing within the specialty groups, and the skewed effect of the distribution. **A motion was made to approve a threshold for quality improvement at no more than 10% of patients using the ≥ 90 MME/day measure. The motion was seconded, and unanimously passed.**

Next members discussed concomitant opioid and benzodiazepine prescribing. The data presented was from a revised analysis that permitted the high-dose opioid and benzodiazepine prescriber to be different people. A member asked whether the data captures individuals on long-term benzodiazepine therapy who receive an opioid following an injury. DHS confirmed that it does. Discussion ensued about the accountability of the opioid prescriber versus the benzodiazepine prescriber. The analysis attributes the patient to the opioid prescriber, and members agreed that it is appropriate to hold the opioid prescriber accountable in terms of harm reduction. A member suggested excluding benzodiazepine prescriptions shorter than one week. Members also discussed whether to exclude very short durations of benzodiazepine therapy, e.g. benzodiazepines prescribed following an emergency department visit or procedure. A member suggested that we only consider prescribers who prescribe both the opioid and the benzodiazepine.

Members discussed possible rates for the QI threshold, including 50% of high-dose COAT patients with concomitant prescribing. Members supported reducing the threshold to an even lower percentage, given the risk of overdose associated with concomitant opioid and benzodiazepine therapy. This patient group is at risk for accidental overdoses, but the group is also at extremely high risk for adverse outcomes if they are abruptly cut off either therapy. Members discussed various alternatives to the measure parameters, including analyzing the second benzodiazepine prescription, including benzodiazepine prescriptions with a duration > 1 week, or a longer duration of overlap. In addition, DHS will consider a quality improvement threshold of 0.33 (33% of a prescriber's COAT patients have a concurrent benzodiazepine prescription).

Finally, the group reviewed the multiple prescriber measure and data analysis. This measure is the number of enrollees receiving COAT who were prescribed opioids from 4+ providers per the number of enrollees receiving at least a 90 day supply of opioids in the measurement year. Discussion ensued about the culpability of the prescribers involved in this behavior, and the behavior of the COAT patients. For example, chronic users may go and get a short-term prescription for acute pain, but this measure does not capture that. It also seems incorrect to hold a COAT prescriber responsible for the irresponsible prescribing of others. Members discussed

whether an acute pain on chronic pain is more appropriate, or whether changing certain measure parameters (e.g., shorter time period for analysis) would make the measure more meaningful. DHS will continue to work on this measure, and present additional measurement options at the next meeting.

Meeting adjourned.