Opioid Prescribing Work Group

Minutes — March 15, 2018
noon – 3:00 p.m.
444 Lafayette Building, St. Paul

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

Members absent: Chris Eaton, Dana Farley (non-voting), Matthew Lewis, Mary Beth Reinke (non-voting), Lindsey Thomas

DHS employees: Titi Adeniyi, Ellie Garrett, Dave Hoang, David Kelly, Sterling Kowalski, Sara Lent, Sarah Rinn

Guests: Kate Erickson (MDH), Juliana Milhofer (MMA), 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 thanked the OPWG members for their commitment and hard work on behalf of the DHS commissioner and deputy commissioner. He provided a brief update on legislation affecting DHS and other opioid-related efforts. The governor's budget will be released next week and it is likely to include an opioid-related package. The recently-passed federal budget included 6 billion dollars for opioid-related activity, but did not include any detail about funding allocation. Schiff provided a brief update on the State Targeted Response (STR) grant and the early successes of the ECHO distance learning project.

Brad Johnson commented that the St. Gabriel's Controlled Substance Care Team/ECHO hub is presenting at the 2018 National Prescription Drug & Heroin Abuse Summit in April.

Approval of Minutes and Opportunity for Public Comment

Members unanimously approved the February meeting minutes.

No public comments were offered.

Rinn reviewed the agenda for the meeting. A copy of her presentation is available upon request.

Chronic Opioid Analgesic Therapy Sentinel Measures

Methodology Review

Rinn briefly reviewed the four chronic opioid analgesic therapy (COAT) prescribing measures domains and definitions. The definitions include:

- **COAT** is a ≥ 60 consecutive days supply of opioids during the measurement period. A ≤ 3 day gap is permissible between prescriptions.
- **Concomitant COAT and benzodiazepine prescriptions** are a ≥ 60 consecutive days supply of opioids and > 7 days overlapping benzodiazepines in the measurement period. A ≤ 3 day gap is permissible between prescriptions, and the 7 day benzodiazepine overlap must be from one prescription.
- **Elevated COAT** is a ≥ 60 consecutive days supply of opioids and the daily dose is ≥ 50 MME during the measurement period. A ≤ 3 day gap is permissible between prescriptions.
- **High-dose COAT** is a ≥ 60 consecutive days supply of opioids and the daily dose is ≥ 90 MME during the measurement period. A ≤ 3 day gap is permissible between prescriptions.

Work group members were asked to consider whether participation in the quality improvement (QI) program should be limited to frequent opioid prescribers. DHS staff presented 2016 data comparing the total number of providers who prescribed opioids to at least one enrollee, the total number of providers who prescribed to ≥ 5 enrollees and the total number of providers who prescribed to ≥ 10 enrollees. Providers who prescribed any opioid to ≥ 5 enrollees represent approximately 62% of all opioid prescribers. Providers who prescribed any opioid to ≥ 10 enrollees represent approximately 46% of all opioid prescribers. Rinn reminded members that the OPIP statute requires reporting to all opioid prescribers, but that there is discretion in who is required to participate in the QI program. Members briefly discussed the merits of waiving infrequent opioid prescribers from the QI program. In general, there was some concern about omitting providers who prescribe significant amounts of opioids to a small number of patients. However, the work group reached consensus that focusing on more frequent prescribers for the QI program is justifiable and an appropriate use of state resources. Work group members agreed that only providers who prescribed opioids to ≥ 5 enrollees in the measurement period are subject to participation in the QI program.

COAT Prescribing Rate

Rinn briefly reviewed the total number of enrollees prescribed COAT using the new COAT definition and a new opioid list. The opioid list is maintained by a national organization, and used in several national, Medicaid measures. The new analysis resulted in 14 fewer enrollees identified as COAT recipients. The rate (12.4% of all enrollees who receive an opioid receive COAT) was unchanged.

High-Dose COAT Prescribing Rate

Work group members reviewed the updated data analysis of high-dose opioid prescribing (dose is ≥ 90 MME/day) and the previously voted-upon quality improvement threshold for high-dose COAT prescribing (prescribing rate ≥ 10%). DHS staff presented data demonstrating the number of primary care providers (and the size of the patient population) who would be required to participate in the QI program. Primary care

providers was used as the example due to high COAT prescribing rates and volume. In general, removing infrequent opioid prescribers from the analysis results in fewer prescribers above the 0.10 prescribing rate, but includes prescribers in both the third and fourth quartile based on prescribing rates. A member asked whether other mechanisms exist to identify infrequent prescribers of high-dose COAT. Schiff affirmed the question, and briefly explained the DHS Drug Utilization Review (DUR) process. A brief discussion ensued about whether special cause variation would be granted to COAT prescribers. One example provided was COAT prescribers at pain clinics. The work group members were in consensus that special cause variation should NOT be allowed for the COAT measures. The measures and QI thresholds permit providers to prescribe above the recommended dose limits for up to 10% of their enrollee patients. However, the risks associated with high-dose COAT are great enough such that even stable COAT patients should be reduced to under the dose recommendations. Members cautioned that providers who practice at pain clinics are likely to oppose this measure.

The work group agreed to keep the QI threshold for high-dose COAT prescribing rates at >10%.

Concomitant Opioid and Benzodiazepine Therapy

Rinn presented updated data for the concomitant opioid and benzodiazepine analysis. Work group members were asked to consider the following issues:

- Should reporting consider concomitant prescribing by the same provider, or allow the prescribers of the opioid and benzodiazepine to be two different people?
- Should the measure use any COAT daily dose, or a specific COAT dose (e.g., 50 MME/day)?
- What is useful to prescribers in terms of reporting, and for a feasible quality improvement process?

Members briefly discussed the increasing use of benzodiazepines, and recent reports about increasing benzodiazepine-related overdose deaths. Indications and common patterns of benzodiazepines were discussed. Members commented on the challenges faced by primary care providers whose patients seek additional care from specialists, and often return to their practice with a benzodiazepine prescription. The primary care provider ends up managing the benzodiazepine prescription. Members unanimously agreed that primary care providers need additional support in this area, and that the QI program must be sensitive to both the challenges presented to prescribers and the high-risk, vulnerable nature of these patients.

Discussion the turned to the first consideration: whether to measure and/or report concomitant prescribing by the same provider or by different providers. Members agreed that providers should always be aware of all of their patient's medications, regardless of the prescriber. However, concomitant opioid and benzodiazepine prescriptions present a unique challenge given the vulnerability of the patient population. One member commented that the opioid prescriber has little control over the first benzodiazepine prescription. However, by the time the second benzodiazepine prescription occurs, there is adequate time for an intervention and consultation between prescribers. Another member commented on the strict protocols he has encountered for patients receiving methadone for opioid use disorder, and concomitant benzodiazepine prescriptions. The member expressed his belief that opioid prescribing should become more onerous, especially for patients who also receive benzodiazepines and other sedative hypnotics.

Discussion turned to the appropriateness of placing responsibility for concomitant prescribing with the opioid prescriber. Members discussed the fact that there is precedent for this in the OPIP post-acute pain prescribing measures. The post-acute pain measure—rate of prescribing 700 cumulative MME—places responsibility on the provider whose prescription exceeds the threshold, regardless of whether the prescriber was responsible for any preceding opioid prescriptions. Members reached consensus to include both scenarios when the opioid prescriber is also the benzodiazepine prescriber, and when they are different, in the measure.

Discussion turned to whether to include all concomitant prescribing (any opioid dose), or to define the measure using elevated dose COAT prescribing (≥ 50 MME/day). Members considered potential process improvements for prescribing: checking the PMP, contacting the benzodiazepine prescriber, tapering either prescription. A member indicated her preference for using elevated COAT dose for the measure. Using the elevated dose may allow people to approach the QI more aggressively, especially since it will limit the number of providers required to participate. Starting with elevated daily doses of COAT also provides prescribers with opportunity to taper the opioid. Members agreed that elevated daily COAT dose is a good starting point, but the measure could be broadened to include all COAT over time.

Once the members agreed upon using an elevated COAT dose for this measure, DHS staff presented data on the number of providers who would be required to participate in QI based on possible thresholds. The data presented used a 10% prescribing rate for all COAT doses, and a 25% prescribing rate for elevated COAT doses as the threshold for QI participation. Schiff commented that using the elevated COAT dose allows the program to more frequently identify prescribers that are putting their patients at elevated risk. Members reached consensus to use 10% as the threshold for quality improvement.

Multiple Prescriber Measures

DHS staff reviewed the data definitions and data analysis for the multiple prescriber measure. The denominator for the measure is the total number of enrollees prescribed COAT during the measurement year. The numerator is the total number of enrollees prescribed COAT who received opioids from 3+ prescribers (COAT prescriber plus 2+ additional prescribers).

Members discussed using 3 providers in the measure versus 4 providers, which is the number used in several national measures. The proposed OPIP measure includes narrower specifications for the timeframe in which concurrent prescribing occurs, so it was reasonable to reduce the number of prescribers. The measure only considers other opioid prescriptions that overlap with a span of COAT. Members also briefly discussed excluding prescriptions that are fewer than 2 days. DHS staff explained that this was done to address overlapping COAT spans. There were a number of instances in the initial analysis where COAT spans prescribed by two different providers overlapped for ≤ 2 days. Members discussed the usefulness of this measure, and ultimately reached consensus that the information is useful but that the measure should not have a QI threshold.

DHS staff then briefly presented data about concomitant methadone (for pain) and benzodiazepine prescribing. This analysis was completed in response to comments received during the December public comment period. A member commented that there is an active national debate about co-prescribing methadone for addiction and benzodiazepines, and less so with methadone for pain. The data presented was informational only, so no action was taken by the work group. Meeting adjourned.