Opioid Prescribing Work Group

Minutes — September 19, 2019
noon – 3:00 pm
444 Lafayette Building, St. Paul

Members present: Julie Cunningham, Sen. Chris Eaton, Tiffany Elton, Dana Farley, Rebekah Forrest, Brad Johnson, Chris Johnson, Ernest Lampe, Matthew Lewis, Murray McAllister, Pete Marshall, Richard Nadeau, Lindsey Thomas

Members absent: Pete Marshall, Mary Beth Reinke, Charles Reznikoff, Charles Strack

DHS employees: Charity Densinger, Ellie Garrett, Tara Holt, Jessica Hultgren, David Kelly, Sterling Kowalski, Sarah Rinn

Guests: Rep. Robert Biermann, Amber Bullington, Audrey Hansen (ICSI), Diane Bolin Kelly, Trudy Ujdur, Lisa Wichterman (DLI), Sophie Wallerstedt (TGE Consulting), Krista Panosian (BioDelivery Services International), Donovan Hurd (Faegre)

Welcome and Introductions

Chris Johnson called the meeting to order. Introductions were made around the room.

DHS Updates

Julie Marquardt (Deputy Assistant Commissioner of the Health Care Administration) welcomed the work group members. She shared that she briefed the new HCA Assistant Commissioner Tony Moss about the OPIP, and affirmed the department's commitment to the project. Marquardt provided an update about the Medical and Behavioral Health director hiring process, and that stakeholders may be invited to participate in second round interview.

Tara Holt (Opioid Integration Specialist in the Community Supports Administration) provided an update about the Opiate Epidemic Response Advisory Council (OERAC). DHS announced the OERAC membership on September 18 and the first meeting is September 27. Holt also announced that an additional 31 State Opioid Response (SOR) grants were awarded, and that the agency received an SOR supplement to target racial disparities. A member asked Holt whether there will be collaboration between OPWG and OERAC. DHS staff will meet about the collaboration shortly.

Approval of Minutes

Lindsey Thomas moved to approve the April minutes, Richard Nadeau seconded. Members unanimously approved the April 2019 meeting minutes.

Opportunity for Public Comment

Diane Bolin Kelly (intractable pain patient) shared her personal pain history. She expressed frustration that the concerns of the chronic pain patient community have not been addressed by the program. She asked that work group members remember the individual people affected by their decisions.

Cammie LaValle (rare disease advocate) expressed concerns that providers are overwhelmed by the various regulations that exist, and that there is confusion about which guidelines should be followed.

Quality Improvement Program

Sarah Rinn reviewed the agenda for the meeting and introduced the quality improvement discussion. A copy of her presentation is available upon request.

Volume thresholds for quality improvement

Rinn reviewed the volume thresholds for quality improvement program participation, and the number of providers, by specialty, above the QI threshold for each measure. A copy of her presentation is available upon request. The OPWG previously determined that QI participation should be based on two factors: 1) exceeding the quality improvement threshold for a given measure; and 2) frequent prescribing in the pain phase. The volume thresholds for the first three measures are based on the number of prescriptions in the measurement year. The thresholds for the COAT measures are based on the number of COAT patients. Establishing volume thresholds allows DHS to effectively target QI resources.

A member inquired about the quality assurance process for the prescribing data included in the reports. He encountered concerns in the provider community that the data is incorrect, or does not match what is found in electronic health records. DHS offered to draft an explanation, and share it with the work group after the meeting. A brief discussion ensued about providers using the PMP to verify the data provided in the prescribing reports.

Objectives of quality improvement program

Discussion then turned to the objectives of the quality improvement program. Rinn recapped the discussion at the April OPWG meeting about whether quality improvement activities should be general in nature or linked specifically to desired prescribing behaviors. DHS staff proposed that quality improvement activities for measures one and two emphasize prescribing opioid therapy only for indicated conditions, and prescribing the appropriate dose for that indication, with normal expected outcomes. A member commented that it would be helpful to include the evidence around dosage and duration with this part of the quality improvement project. DHS confirmed that this can be included in educational materials for the project.

Members discussed challenges around the practice of only prescribing for indicated conditions. The group then discussed scenarios in which there is no evidence on indications, or the appropriate dosage for the indication. Members also commented that while this type of work is going on for procedures, it may be much more

challenging for indications that are unrelated to a procedure, such as acute back pain. A member requested that DHS use the term "lowest effective dose" rather than "appropriate dose" for any given indication.

A member of the public requested clarification around two items: 1) do the DHS guidelines recommend using short-acting opioid therapy in the acute pain phase; and 2) who would determine whether a condition is indicated for opioid therapy and the appropriate dosage? DHS staff indicated providers would attest and/or demonstrate that this type of work occurs, but that DHS not request a list on indicated conditions.

Members briefly discussed that there are conditions for which opioids *are not* recommended, and that we seem to be on the right track for adaptive change on measures one and two. Chris Johnson called a vote on the proposal to focus quality improvement activities on dose and indication for measures one and two. The proposal was unanimously approved.

Geographic considerations for quality improvement program

A member asked whether the quality improvement activities should consider practice size and geographic location of the provider. Providers who practice in isolated areas and/or people with solo or very small practices do not have access to the same resources as those who practice in metro areas or in large health systems. DHS staff acknowledged this setback and confirmed that the QI requirements and expectations will take it into account. Another member commented that the onus of responsibility for QI seems to be shifting from individual providers to health systems and employers.

Quality improvement in post-acute prescribing

The discussion moved on to quality improvement goals in the post-acute pain phase. DHS proposed that quality improvement activities focus on implementing standardized screenings and assessments for patients requesting ongoing opioid therapy. Members briefly commented that the 45-day window for post-acute pain now seems lengthy given the current state of the evidence on early exposure to opioids and risk of long-term use. However, because this measure targets behavior that is most difficult to change, the group agreed it is too early to narrow the 45 day window for the state's QI work. ICSI staff commented there is increasing evidence in the medical literature about exposure to opioids in the post-acute pain phase and risk of long-term use.

A member asked whether the QI program would require specific risk assessment tools. DHS answered that the attestation form will likely ask for standardized assessment, but not require a specific tool. Johnson called for a vote about the QI approach for post-acute pain. Members approved the approach.

Quality improvement in COAT prescribing

Rinn reviewed the proposed goals for measures 5 and 6 after the break. DHS staff suggested moving on to the next agenda item, given the overlap between the two topics, and returning to the discussion of the measure 5 and 6 objectives if needed.

DHS introduced the next section by acknowledging increased concerns that the QI program may create incentives for providers to practice sub-standard care to reduce their prescribing rates. It is critical that DHS' QI program does not dissuade providers from caring for complex, chronic pain patients. Members discussed approaches to minimize the potential for unintended consequences and poor patient care.

Members briefly discussed measuring patient retention. DHS stated that initial work around patient stability and retention has started. This work also includes how to discourage the practice of abrupt tapering. A member asked that DHS use the term "inappropriate referrals" as opposed to "unnecessary referrals". This language reflects circumstances when referring to a pain specialist or integrated pain clinic is appropriate. The discussion next turned to patient abandonment. DHS data will not be able to decipher whether the patient has abandoned the provider or vice versa. Cammie LaValle suggested that the state provide resources for patients who are abandoned by their provider. She stated referrals to new clinics are often challenging, and patients are often required to revisit treatments that they have previously attempted

DHS proposed three options for minimizing any unintended consequences related to the QI program:

1. Should the quality improvement program take an incremental, phased approach for high volume prescribers?
2. Should there be a way to satisfy the QI criteria without demonstrating prescribing rate reductions for any or all the measures?
3. Should the QI program be implemented in full in QI year one for high volume prescribers? Providers who are unable to satisfy the QI requirements based on the nature of their practice will require a special cause exemption.

Members discussed whether phasing in the program will create more trust with providers. There was emerging consensus that the education piece is critical but waiting until QI year 2 is too long. Members agreed that the health systems and providers will be ready for QI by 2020. Members briefly discussed the special cause exemption process, which has not yet been determined.

Tapering

Members discussed the general lack of knowledge of appropriate tapering procedures among clinicians. This has created a lot of anxiety in the medical community about managing patients on long-term opioid therapy. All agreed one of the challenges associated with tapering patients is that tapers must be tailored to the patient's unique treatment needs and resources. The group stated a challenge facing DHS is how to educate the COAT community about appropriate tapering in a way that keeps pace with the QI program.

Members all agreed tapering should occur in a multi-disciplinary environment. Additionally, it is important that patient referrals are to providers who are appropriate for COAT management. Providers who are required to participate in the QI program must demonstrate that they are making appropriate referrals for tapering or describe the barriers that they encounter.

Members agreed to pause conversation about the QI program for the duration of the meeting, given the need to address other items on the agenda. DHS will process the conversations and votes from the meeting and draft the attestation form for review in October.

Prescriber reports debrief

Ellie Garrett presented information about the initial opioid prescriber report distribution and feedback. A copy of the slides are available upon request. The group discussed possible ways to improve the distribution process. DHS described potential changes to the statute that would allow the state to distribute the reports in

bulk to the health systems. Another member suggested that DHS think about addresses from other sources, for example, the Board of Medical Practice.

Rinn briefly shared that CHI St. Gabriel's received a grant from Stratis Health to fund a time limited ECHO related to the DHS opioid prescriber reports. DHS staff will email the proposed curriculum to the OPWG members for review and comment.

Chair Johnson re-opened the public comment period at the end of the meeting. Jeff Schiff thanked the members for their leadership and advocacy of the project. He provided a few personal updates, including that he is leading a national set of quality measures around opioid prescribing. The body has adopted two of the measures—New Chronic Use and the 700 MME cumulative exposure—developed to support the OPIP.

Meeting adjourned.