

Opioid Prescribing Work Group

Minutes — December 19, 2019

noon – 3:00 pm

444 Lafayette Building, St. Paul

Members present: Julie Cunningham, Sen. Chris Eaton, Dana Farley, Rebekah Forrest, Chad Hope, Ifeyinwa Igwe (remotely), Brad Johnson, Chris Johnson, Ernest Lampe, Murray McAllister, Pete Marshall, Richard Nadeau, Charlie Reznikoff (remotely), Charles Strack, Lindsey Thomas, Matthew Lewis

Members absent: Tiffany Elton

DHS employees: Ellie Garrett, Jessica Hultgren, David Kelly, Sarah Rinn (remotely)

Guests: Representative from the Office of the Inspector General Restricted Recipient Program, Nancy Cox, Sheila Grabosky,

Welcome and Introductions

Chris Johnson welcomed members and introductions were made around the room.

DHS updates

Ellie Garrett provided a brief update on recent agency activities. DHS Commissioner Harpstead presented her 90-day plan and continues to announce appointments to key DHS leadership positions. Gertrude Matemba-Mutasa is the new Assistant Commissioner of Community Supports. Dr. Nathan Chomilo is the new Minnesota Health Care Program Medical Director. Dr. Chomilo is an internist/pediatrician, practicing at Park Nicollet. He will start in early February.

The 2019 opioid prescribing reports are expected to be sent out in the last week of December 2019.

Approval of minutes

The November OPWG meeting minutes were not approved due to a page missing in the packet. The minutes will be provided for review at the first meeting in 2020.

Opportunity for public comment

Nancy Cox (chronic pain patient) provided a brief public comment. She commented that the group should not assume that a chronic pain patient will be disruptive. Patients who participate put a human face on the issue, and it takes courage to speak truth to power. She encouraged the group to keep an open mind.

Sheila Grabosky (chronic pain patient) also provided public comment. She appreciated the opportunity to participate in the listening session in early December. The three messages she took away from the meeting included: 1) the CDC guidance significantly impacted people's lives; 2) there is a major effort to drop people to

50 MME or less; and 3) that 50 MME/day is not sufficient for some people. She commented she would not need opioid therapy if she had daily access to other treatment modalities, but cost and access is an issue. Chronic pain patients who use opioid therapy are forced to play games with their insurance companies in order to get the care they need.

Program Updates

Garrett informed the group that Commissioner Harpstead approved a 2-year extension of the OPWG. Members were encouraged to submit their applications. DHS recently hosted two stakeholder meetings. The first was for health systems across the state, convened by DHS, MHA and ICSI. The meeting was well-attended and highly collaborative. Chris Johnson and Murray McAllister attended in person, Ernest Lampe attended remotely. Health systems are interested in seeing aggregate data for their providers. A member asked whether DHS will re-run reports for physician assistants and advance practice nurses, given the potential for the change to affect the aggregate data. Health systems also expressed a desire to help DHS distribute the reports. DHS informed participants that to do so will require legislative change, and staff are working with partners to pursue this legislation. The next steps include: a) ongoing communication about reports to providers via health systems, b) pursuing a legislative change to assist with distribution, and c) ongoing communication about the program facilitated by MMA, MHA and ICSI.

The second meeting was a listening session for chronic pain patients. Julie Cunningham and Ifeyinwa Igwe attended remotely; Charlie Reznikoff attended in person. One of the members who participated commented that she heard that chronic pain patients feel stuck in the middle, they are receiving a lot of push back from providers, but that they appreciate the opportunity to share their experience with the state and OPWG. Approximately 50 people attended in person, and an unknown number of attendees participated by phone. Fourteen individuals provided public comment, and 28 people provided written comments. Four overarching themes were present in the public comment: 1) Anxiety and depression are common conditions for those in chronic pain; 2) Patients on long-term opioid therapy have often exhausted all other therapeutic interventions; 3) Starting over with a new clinic or new provider is often frustrating; and 4) Chronic pain patients and advocates want representation on the OPWG. All public comment from the meeting is available by request, along with a summary of those themes.

Garrett asked the group to entertain a motion to add up to two non-voting members representing the voice of chronic pain patients. She explained that the work group can vote to add two non-voting members, but that the statute must be modified to make them voting members. Discussion ensued among the members. Several members expressed support and commented that it would help with buy-in among the chronic pain patient community. Other members commented that there must be recognition that one or two people cannot be expected to universally represent all chronic pain patients. Members requested the DHS ensure that the patients are not surrogates for pharma. Discussion turned to the number of patients added. Members questioned why we would add two seats, when many of the other positions are represented by one person. Garrett commented that this would maintain parity with the consumer members. A member proposed adding two patients: one who continues to use chronic opioid analgesic therapy, and one who does not. Consensus emerged around this proposal. **A motion was made to add two non-voting positions for public members with chronic pain. One position will be for a person currently on COAT, and one who previously used COAT. The motion was seconded and approved.**

A brief discussion ensued about the vetting process. The seats will not initially be added as voting positions because the statute already specifies the voting members. There was agreement that DHS will fill the seats with non-voting members and will then work with a partner to carry a legislative change which would make them vote.

Quality Improvement (QI)

Garrett reviewed the proposed process of using attestation forms to gather information from providers flagged for quality improvement. The work group started with the QI activities identified for the chronic pain measures. The primary change to the revised process to have DHS engage with quality improvement or other relevant staff at the system, clinic or department level when a provider is flagged for QI and there is an existing quality improvement effort underway in that setting. This may allow DHS to work more efficiently with systems who have multiple providers flagged for QI. A member commented that this is going to be very difficult for dentists and others in solo or small practices.

Discussion began with the continuing education requirement. Members were asked to consider whether any pertinent QI completed in 2020 could meet the CE requirement. Discussion ensued about the appropriate vetting of CE submitted as part of the QI. Members were reminded that DHS staff are responsible for the programmatic implementation. A member commented that there have to be objective criteria. A suggestion was made to create a registry of approved content.

Members expressed concern about most providers' understanding of QI. The term 'Quality Improvement' is not widely known and it means different things to different people. It was suggested that DHS reach out to Minnesota Community Measurement to get more guidance on standardization. Additionally, DHS should keep this confusion in mind in developing OPIP communications. There is a high degree of variability of how QI is administered in different types of settings, specialties, geographies, etc. A member commented that there is a broad spectrum of QI projects in health care settings. There are some early adopters, but many are not as far along as we think. The group expressed uncertainty about DHS's approach of deferring to the health system's existing QI programs. The group expressed a need for more guidance here.

Discussion continued about the challenge of identifying providers for quality improvement, and working with systems to ensure best practices and appropriate standard of care policies are in place. A member commented that most QI work is done behind the scenes, and that it takes considerable resources. Members do not think that case review is as common as perceived, and when it is in place it is supported by non-physicians. Garrett interjected and identified the contradiction expressed by the members: the current approach is both too much of a burden for individuals and systems; and yet we are asking for may not be enough to change practice.

Members then turned to the language in the attestation forms. One member criticized the use of the words guideline and recommendation in the QI forms, and expressed that "Best Practice" or "Standard of Care" may be more accurate. DHS requested guidance for next steps, and a member commented that DHS should reach out to quality improvement experts. A member strongly encouraged DHS and the work group to get the QI standards out as soon as possible. Another member suggested thinking about the QI guidance in two buckets: 1) providers and small practice and 2) health systems.

Other Business

Members were encouraged to apply for the upcoming term of the OPWG on the Secretary of State's website. The group will not meet again until the new slate of members is appointed. DHS staff and the work group honored Pete Marshall, who has decided not to reapply for this position.

Meeting Adjourned.

DRAFT