Opioid Prescribing Work Group

Minutes — October 21, 2021
12:00 pm –3:00 pm
WebEx Video Event

Members present: Emily Bannister, Nathan Chomilo, Kurtis Couch, Julie Cunningham, Kurt DeVine, Chris Eaton, Tiffany Elton, Dana Farley, Rebekah Forrest, Bret Haake, Chad Hope, Chris Johnson, Murray McAllister, Richard Nadeau, Adam Nelson, Charlie Reznikoff, Saudade SammuelSon, Lindsey Thomas

Members absent: Matthew Lewis, Charles Strack

DHS employees: Ellie Garrett, David Kelly, Jessica Hultgren, Melanie LaBrie, Sarah Rinn

ICSI staff: Audrey Hansen

Welcome and introductions

Julie Cunningham called the meeting to order and welcomed members. Opioid Prescribing Work Group (OPWG) members introduced themselves. Members reviewed the September OPWG meeting minutes. Lindsey Thomas moved to approve the minutes, with the changes identified below. Chris Johnson seconded the motion, and the minutes were approved unanimously.

- Bottom of page 4: Change the word 'form' to 'from'
- Top of page 5: Change the word 'them' to 'the'
- Middle of page 5: Change the word 'Member' to 'Members'

State agency updates

Ellie Garrett shared that the Department of Human Services (DHS) posted a Request for Proposals (RFP) to create a Project ECHO hub for opioids, including treatment of Opioid Use Disorder (OUD). The RFP is available on the DHS web site under Partners & Providers, Grants & RFPs.

Dana Farley shared highlights from the recent Minnesota Department of Health (MDH) report on nonfatal drug overdoses in 2020. There was an 18% increase in nonfatal Emergency Department (ED) overdoses, even though overall ED visits decreased during the COVID-19 response. The nonfatal overdoses were driven by synthetic opioids, stimulants and benzodiazepine use. He also shared that MDH is working with the Board of Pharmacy to improve reporting of overdose data on the Minnesota Prescription Drug Monitoring Program (PMP).

Opportunity for public comment

Sarah Rinn reviewed the three resources shared ahead of the meeting as part of the public comment opportunity. The resources were shared by members of the public, and included:

1. American Medical Association. 2021 Overdose Epidemic Report.
2. Nadeau S, We J and Lawhern R. Opioids and chronic pain: An analytic review of the clinical evidence. Frontier of Pain Research. 17 August 2021.
3. News stories about a recent decision by Blue Cross Blue Shield of Minnesota to end network affiliation with the Center for Pain Management.

NOTE: The individual who shared the news stories about the Center for Pain Management did so out of concern about the patients who now may need assistance finding a new care provider. DHS staff shared that the DHS Managed Care Unit has been working with BCBSM to make sure that all affected patients have been contacted and are being transitioned to a new provider. More than that, we cannot say. Provider networks are not the purview of the OPWG.

Cammie LaValle disclosed that she has no financial conflicts of interest. She asked if there is information about the current number of COAT enrollees. Ms. LaValle shared her concern that the data presented during the September OPWG meeting indicates that between 2016 and 2020, 51,000 Medicaid enrollees discontinued their opioid therapy. Based on the data analysis, many of these tapers were abrupt. She asked whether anything has been put in place to reach out to the patients who were discontinued off of their medications. And if not, will it be addressed moving forward?

Sheila Grabosky disclosed that she has no financial conflicts of interest, and shared multiple concerns she has about this project. First, she is concerned that this work group is targeting vulnerable populations who suffer from chronic pain unfairly, given that these populations may have less resources to seek out alternative pain treatment options. Second, she is concerned that the project still does not recognize that there are patients who are structurally compromised. These patients need opioid analgesia to maintain quality of life, and should not be tapered. Ms. Grabosky specifically stated that Chris Johnson stated that it is easy to taper down during the May OPWG meeting, and admonished the work group for this. Fourth, she commented on the upcoming revisions to the CDC opioid prescribing guidelines, and concerns about potential conflicts of interest among its authors. Fifth, she commented on the fact the overdose death rate has not decreased, and these is insufficient attention paid to the benefit experienced by patients who use opioid analgesia to managed chronic pain. And finally, she requested that the OPWG use the term Substance Use Disorder instead of Opioid Use Disorder.

NOTE: DHS staff reviewed the May 2021 OPWG meeting transcript, recording and minutes. Chris Johnson did not state that tapers are easy at any point during the meeting.

Opioid Prescribing Improvement Program sanction standards

Rinn introduced this agenda item by reviewing the task set forth to the OPWG: develop clinical definition of unacceptable practice as it relates to opioid analgesic prescribing. These practices may be subject to sanction by the DHS Office of Inspector General upon investigation. A copy of her slides is available upon request.

Abrupt taper to discontinuation

Rinn reviewed the proposed definition: *In the case of a patient undergoing a chronic opioid analgesic taper from a dose greater than (50 or 90 MME/day), a pattern of practice that is inconsistent with the community recognized standards for an opioid taper.*

Practices that are inconsistent with the community standards of care include:

a. *Failing to document a clinical rationale for the opioid taper and for the taper plan or speed;*
b. *Failing to provide adequate follow-up care during the taper;*
c. *Failing to document a safety and pain management plan during the taper;*
d. *Failing to assess the patient for Opioid Use Disorder (OUD) and refer or treat as appropriate;*
e. *Failing to communicate with the patient about the taper;*
f. *Failing to address and document patient harm if it arises during the taper. This includes known harms reported by the patient or evident in a clinical situation, as well as harms that should have been known through adequate chart review.*

Members discussed whether to use 50 MME/day or 90 MME/day as the dose threshold for this standard. Currently, there is no evidence to identify a specific dose as a predictor of harm as it relates to a taper. Harms are associated with increments of dosage decreases and the time intervals between the decreases. Discussion ensued and members reached consensus to use a daily dose of ≥ 50 MME/day for this standard.

Discussion turned to item 'a': Failing to document a clinical rationale. Members discussed whether the criteria should also include presence of a non-clinical motivation for an abrupt opioid taper. There is ample anecdotal evidence that prescribers are tapering or ceasing opioid therapy due to convenience or self-protection—or are stating that they are required to do so by outside entities. Members agreed that this is occurring, but that it seems unlikely that this could be discovered as part of a chart review. This may be a criterion that could be used to open an investigation, if it is reported to DHS.

A member commented that adequate patient follow-up should occur both during *and following* the taper, and recommended adding 'and following' to item b. Another member questioned whether there needs to be some consideration of social justice or repairing the harm done to patients who are forcibly tapered or abandoned by their clinician.

Discussion turned to whether to use Opioid Use Disorder (OUD), or Substance Use Disorder (SUD) in the sanction standard definitions. SUD includes OUD, but there is a heightened concern about OUD during an opioid taper. The presence of an OUD is clearly linked to the outcome of an opioid taper. A member expressed concern that some clinicians are documenting a diagnosis of OUD among all patients using opioid therapy for chronic pain. Members reached consensus that the assessment should be for an active, moderate to severe SUD, and particular an active, moderate to severe OUD.

Members discussed interruptions of opioid therapy due to a disruption in care or a disorganized clinic or prescriber. This is also a concerning practice. Patients who are unable to get a refill due to a disorganized practice will seek out care in the Emergency Department, resulting in poor health care utilization. Disruptions in care can also occur when a patient has a chaotic life, or a stressful event exacerbates pain and the patient needs more medications. There was emerging agreement that this situation should be addressed, but not in the taper section. It may be appropriate under the high dosing domain, or a separate domain that addresses an organization's policy to cover each other's patients and protect patient care.

Excessive dosing without risk mitigation

Rinn reviewed the proposed definition: *For patients receiving greater than (400 or 500) MME per day, a pattern of practice that fails to meet the community standard of care for patients on a high-risk dose of COAT. The following practices fail to meet the standard of care:*

a. *Failing to assess and document the diagnosis or diagnoses indicated for long-term opioid analgesia;*

b. *Failing to assess and document comorbid health conditions;*
c. *Failing to screen and document opioid-related risk of harm;*
d. *Failing to assess for diversion;*
e. *Failing to assess and document appropriate response to Opioid Use Disorder (OUD);*
f. *Failing to document clinical decision making if dose is increased; and*
g. *Failing to document discussion of an opioid taper on at least an annual basis.*

Members discussed whether to use 400 or 500 MME/day for this domain, and consensus emerged that 400 MME is appropriate. Defining very high doses at ≥ 400 MME/day is based on clinical experience and expert opinion, as well as the data analysis completed for the September OPWG meeting. The data analysis found a small proportion of patients with daily doses exceeding 400 MME/day. A member cautioned against introducing a new number into policy or regulation, given the unintended consequences associated with dosage recommendation in prescribing guidance. Members agreed to remove the term "indicated" from item 'a', and revising item 'c' to state "Failing to screen and document patient-centered opioid-related risk benefit analysis.". Members also agreed to add an additional criteria: failing to respond to actual harm; and failing to prescribe naloxone.

Discussion turned to whether the standard needs to address how frequently the patient is evaluated by the provider. Members supported frequent clinical visits based on risk. A member expressed concern for costs associated with each visit. The DEA requires that providers evaluate patients receiving controlled substances at least every three months. A member commented that it is not only the very high doses that are concerning, but also illogical prescribing patterns that may indicate diversion. If a prescription is illogical or the dosing schedule is illogical, it should be a red flag.

A question arose about whether all of the items needs to be present, or if just one needs to be present to be sanctioned. DHS staff indicated that those judgement calls can be the purview of the OIG team, but will follow-up and confirm. Discussion ensued about dose escalation, and appropriate clinical decision making and documentation of dose increases.

Concomitant prescribing of opioid with other medications

Rinn reviewed the proposed definitions:

1. *A clinician shall not initiate concomitant chronic opioid analgesic therapy and long-term benzodiazepine therapy without the following:*
   a. *Documentation of the clinical rationale for initiating therapy, including assessment an documentation of risk factors and trials of first line therapies for the condition for which the benzodiazepine is prescribed;*
   b. *Screening and appropriate treatment or referral for substance use disorder; and*
   c. *Documentation of a safety plan.*

2. *A clinician shall not knowingly initiate chronic opioid analgesic therapy to an individual receiving benzodiazepine therapy from another clinician without the following:*
   a. *Documentation of the clinical rationale for initiating therapy, including assessment and documentation of risk factors;*
   b. *Screening and appropriate treatment or referral for substance use disorder;*

c. *Documentation of a safety plan; and*
d. *Communication with the benzodiazepine prescriber.*

If the benzodiazepine is listed in the Minnesota Prescription Monitoring Program, the clinician is presumed to know about it.

3. *A clinician shall not knowingly continue long-term concomitant chronic opioid analgesic and benzodiazepine therapy without the following:*
   a. *Documentation of the clinical rationale for continuing long-term opioid analgesic and benzodiazepine therapy;*
   b. *Documentation of assessment for a history of or current substance use disorder; and*
   c. *Documentation of a safety plan; and response to evidence of harm within the medical chart. Evidence of harm may include falls, accidents, non-fatal overdoses, appearing sedated at clinical visits or reporting forgetful events.*

A brief discussed ensued about the phrase 'evidence of harm' in number 3.c., and a recommendation was made to change the word evidence to examples. Discussion turned to using the phrase 'continuing long term concomitant opioid and benzodiazepine therapy'. A member expressed concern about sanctioning clinicians and patients who are working to reduce the dose in response to the risk, but continue on both medications. Does this mean anything short of cessation is problematic? Concomitant prescribing elevates the patient's risk of harm, but it can take time to address the situation and taper one or both medications. Several members expressed concern about the number of clinicians who could be subject to this, given this is a very common situation and one where there has not been a lot of change in practice. This standard should be focused on the most egregious instances of concomitant prescribing.

Members began to reach consensus that knowingly initiating long-term concomitant opioid and benzodiazepine therapy could be a sanctioned behavior. This would include both simultaneous initiation of both therapies—which is probably less common—as well as starting one therapy once the other is already established. There should be evidence that the intent of both is for daily or regular use. A member shared her experience of using both medications, and shared that she was not educated on the high risk of harm associated with taking both of these medications. She strongly supported holding clinicians accountable for clearly communicating the risk of harm associated with these medications.

Opioid prescribing resource updates

Minnesota Hospital Association (MHA)

Rinn reviewed recent opioid prescribing and opioid stewardship resources developed by the Minnesota Hospital Association. DHS supported the creation of these resources through the federal State Opioid Response grant. The resources are available on the MHA web site.

Institute for Clinical Systems Improvement (ICSI)

Audrey Hansen provided a brief update on the OPIP quality improvement program, and the chronic pain human design work. A copy of her slides is available upon request. She shared that the chronic pain participants in the human design work were asked about scenarios when the benefit of continuing opioid therapy or even increasing doses outweighs the risk of harm. ICSI received 70 responses to the questions, and is currently compiling the responses. They are also working on refining the principles of care identified through

the cohort work. Hansen also provided an update of how the ICSI-developed pain and opioid resources will be kept available once ICSI has closed.

Meeting adjourned.