



Health Services Advisory Council

Minutes — November 12, 2015
4:00 – 5:00 p.m.
Via Conference Call and WebEx

Members Present

Don Brunquell, Howard Fink, Andrea Hillerud, Chris Johnson, Jim Miner, Tamiko Morgan, Jeff Schiff (non-voting), Cedric Skillon

Members Absent

Amelia Burgess, Patrick Irvine, Timothy Sielaff (chair)

DHS Staff Present

Ellie Garrett, Robert Lloyd, Sarah Rinn

Others Present

Sharon D'Agostino (Johnson & Johnson)

I. Welcome, introductions, updates and minutes

Ellie Garrett chaired the meeting in Tim Sielaff's absence. Garrett welcomed Chris Johnson, an emergency medicine physician practicing with Emergency Physicians Professional Association and based at Park Nicollet Health Services. Johnson has joined HSAC as a new member and has also agreed to do double duty by representing HSAC at DHS' new Opioid Prescribing Work Group (OPWG).

After participants introduced themselves, **HSAC members voted to approve the September minutes with no corrections.**

Jeff Schiff provided DHS updates:

- The OPWG will meet for the first time on November 23. The OPWG will focus first on acute pain prescribing protocols, measures and messaging to providers. The group will discuss opioids for post-acute and chronic pain later. The legislatively mandated Opioid Prescribing Improvement Project, of which the OPWG is a key part, grows out of HSAC's 2014 input on opioid analgesia.
- A request for proposals for technical support (to be provided to integrated perinatal care collaboratives) will be released soon. This is a building block for the legislatively mandated project to target resources in communities with high rates of low birth weight or neonatal abstinence syndrome.

- The Behavioral Health Homes (BHH) program will launch July 1, 2016. DHS has submitted a Medicaid state plan amendment for approval to CMS. The target population is adults with serious mental illness and children with emotional disturbance. In response to a question, Schiff clarified that the BHH model will have a certification process analogous to the Health Care Home program. BHH is available to primary care providers and community mental health providers so long as they provide the relevant integrated services. Primary care providers will need to bring in mental health services and mental health providers would need to bring in physical health services.

II. Presentation and Discussion: Too Many and Not Enough: Measuring What Matters

Schiff and Robert Lloyd introduced the topic of DHS' proposed strategy for improving quality measurement. A copy of their presentation is available upon request from [HSAC staff](#). The presentation's purpose was to introduce the [Institute of Medicine's Vital Signs](#) report as a basis for rethinking quality measurement at DHS. DHS annually produces over 100 HEDIS and AHRQ prevention quality indicators, many of which are similar but with slight technical specification modifications to meet specific measurement purposes (such as financial incentives or federal grant requirements). Reducing the annual measurement production burden would allow more in-depth analysis and development of new, higher-level population health and well-being outcome measures. In brief, the presentation outlined the possibilities of measuring more clinical outcomes and fewer processes. Lloyd asked HSAC for feedback on implementing the IOM Vital Signs Core Metrics concepts to achieve a statewide outcome measurement plan. He closed with two questions: (1) What are the benefits and challenges in developing an improved and aligned core set of outcome measurements? (2) Would HSAC recommend changes to the *Vital Signs* four domains of influence, associated elements and core measures?

A member asked whether it was realistic to assume that it's possible to reduce the measurement burden. He observed that focusing on *Vital Signs* measures might prompt an unintended consequence of adding measures without reducing others. He asked whether DHS had identified existing measures that could be removed without violating state law or federal requirements. Schiff acknowledged his concerns, and suggested that the place to start is to begin the conversation and impose some discipline. For example, CMS is developing a quality measurement set for pediatric accountable care organizations. We need to advocate strongly for overlap with the child core set of measures for Medicaid.

Another member observed that data for outcome measures can be harder to collect than administrative data for many outcome measures. The burden in capturing data must be considered. That said, it's a good idea to retire process measures that do not contribute meaningfully to improving health or health care.

Schiff stated that with this presentation, HSAC was being brought into the conversation at DHS very early. He would provide periodic updates to HSAC, but stated that this topic would likely not be on the agenda for every meeting in the near future.

A member expressed support for moving to outcome measures, but expressed concern that the measures would add to the current burden. Schiff observed that the magnitude of changing direction on quality measurement would require collaboration.

III. Public Comment

Sharon D'Agostino stated that Johnson & Johnson is very engaged in quality initiatives, and she appreciated the opportunity to stay abreast of DHS' work in quality measurement.

IV. Other Business/Next Steps

Garrett reminded HSAC members that there was no meeting scheduled for December. The next meeting would be in person at DHS' Andersen building.

The meeting was adjourned at approximately 5:00 p.m.



Health Services Advisory Council

Minutes — September 10, 2015
3:00 – 5:00 p.m.
Andersen Building, St. Paul

Members Present

Don Brunnquell, Amelia Burgess, Howard Fink, Andrea Hillerud, Tamiko Morgan, Jeff Schiff (non-voting), Cedric Skillon

Members Absent

Patrick Irvine, Jim Miner, Timothy Sielaff (chair)

DHS Staff Present

Ellie Garrett

Others Present

Jim Abeler (Acupuncture and Oriental Medicine Association of Minnesota), John Blaska, (Acupuncture and Oriental Medicine Association of Minnesota), Brad Christensen (Xerox Government Healthcare), Erin Huppert (Allina Health), David Kunz (Northwestern Health Sciences University), Mimi Le (University of Minnesota student)

I. Welcome, introductions, updates and minutes

In Timothy Sielaff's absence, Jeff Schiff chaired the meeting. Schiff welcomed members and guests, and introductions were made around the room. **Minutes of the April and June meetings were approved with no corrections.** Schiff provided updates on the recent statewide opioid summit and the launch of the new benefit for early intensive developmental and behavioral interventions to treat autism in children.

II. HSAC membership status and election of HSAC chair

Ellie Garrett announced that two members' terms had been renewed (Andrea Hillerud and Sielaff), and DHS is in the final stages of reviewing applications for three other slots left vacant due to resignation or term expiration: (Lance Hegland, William Parham III and Katie Pieper). Schiff announced that Sielaff had expressed willingness to continue serving as chair. **On motion made and seconded, the council unanimously voted to re-elect Sielaff as chair.**

III. Presentation: Wrapping up discussions of acupuncture

Garrett reminded HSAC that its goal was to make recommendations regarding whether to expand acupuncture coverage to more indications, and if so, which. Acupuncture is currently covered for treatment of chronic pain that has lasted six months or longer. She summarized HSAC's acupuncture discussions to date concerning a range of indications and presented on the results of a MED literature review regarding acupuncture's efficacy to treat breech presentation and post-stroke depression. A recent Cochrane review identified two small randomized controlled trials that indicated that acupuncture plus moxibustion is more effective at decreasing breech presentation than waitlist controls. Two different systematic reviews reported that acupuncture is either equivalent or more effective at reducing post-stroke depression severity than treatment with antidepressants. However, the clinical significance of these reductions are uncertain. Consistent with literature on other indications for acupuncture, there are numerous limitations in the literature pertaining to breech presentation and depression: Small sample sizes; blinding/high risk of bias (concerns with unknown sequence generation, allocation concealment and other blinding techniques); selective outcome reporting; and lack of standardization in treatment and study methods.

Garrett offered some considerations for HSAC: Acupuncture evidence is limited but growing; ratio of possible benefit compared to risk is high; continuing coverage based on initial response to therapy is possible; and tracking of co-occurring therapies is possible.

Based on the various MED summaries to date, the VA's evidence maps for acupuncture (see attachment 1) and public input, DHS staff recommends covering an expanded list of indications, having balanced acupuncture's low risk and relatively low cost with the potential for benefit, especially in comparison to competing therapies. The new indications are those that the VA's evidence maps rate with a moderate to high confidence level as demonstrating either potential to actual evidence of effectiveness. Staff further recommends that these indications be expanded to reflect more recent input from public comment and experts and the MED project. A copy of Garrett's PowerPoint slides was circulated in advance of the meeting and is available upon request from [HSAC staff](#).

IV. Opportunity for public comment

No public comments or questions were raised at this time.

V. Discussion and recommendations regarding coverage for acupuncture

Schiff drew members' attention to a handout summarizing staff's draft recommendations, which is appended as Attachment 1. Members discussed the utility of offering acupuncture as an alternative to opioids earlier in the pain cycle, without waiting for pain to last six months or longer. Members also discussed the placebo effect shown in the literature, and some commented that a placebo effect is beneficial in circumstances where the effect is subjective, so long as in this case the risk of the intervention is so low. A member asked about the availability of acupuncture throughout the state, and John Blaska from the audience replied: According to Blaska, there are approximately 500 acupuncturists licensed in Minnesota, roughly half of whom are currently in practice. He stated that more would go into practice if insurance coverage were more readily available for their services. Approximately 60% of the acupuncture workforce is based within 50 miles of the Twin Cities metro area.

Members discussed the sufficiency or insufficiency of the current body of evidence. One member observed that competing therapies for some of the indications being discussed have equally, if not more, limited evidentiary bases in the literature. Another member queried whether people might seek acupuncture at the expense of more proven interventions. In response, the point was made that acupuncture should be viewed as an opportunity for integrative treatment, not an either/or option. Blaska noted that acupuncturists are licensed, board-certified professionals who are required to refer cases that are beyond their scope of practice or capacity to treat.

A member suggested that DHS could contribute to the body of knowledge about acupuncture's relative effectiveness by expanding coverage, gathering outcomes evidence and reporting results back to HSAC. Another member pointed out the inherent selection bias in retrospective analysis based on registry data.

Returning to the proposed list of indications, a member suggested that adding acupuncture to the list of available treatment options for mental illness would be useful; current treatments are often increasingly complex and untested medication combinations. Another member stated that the list seems sensible, reflecting an appropriate balance of risk and benefit. A different member expressed serious concern about the relative paucity of evidence of effectiveness, pointing out that the VA evidence maps were not created with the same, high standards as we expect from other sources such as AHRQ.

Discussion concluded, and the matter was put to a vote. **A motion was made and seconded to adopt the indications list proposed in attachment 1. The motion carried, with one member voting nay.**

Jim Abeler comment that the recommendations are a good start and that he expected that DHS' costs would go down as more patients have access to inexpensive interventions such as acupuncture. He urged the agency to consider carefully what prior authorization requirements it would impose because of the administrative costs associated with authorization processes.

VI. Other business/next steps

Schiff reported that possible topics for HSAC in the near future might include home-based sleep studies, puberty suppression for gender dysphoria, and quality measurement strategies in light of the new IOM report, [Vital Signs: Core Metrics for Health and Health Care Programs](#). Topic nominations from HSAC members are welcome.

The meeting was adjourned at approximately 4:35.

ATTACHMENT 1: DHS STAFF RECOMMENDATIONS FOR HSAC'S CONSIDERATION

Recommended Expansion of Indications for Acupuncture

Background: Acupuncture is currently covered for chronic pain lasting six months or more. In response to provider concerns, the DHS' benefit policy staff requested the Health Services Advisory Council to discuss expanded indications for acupuncture coverage within Minnesota Health Care Programs.

Relevant Minnesota law states:

- Medical assistance covers acupuncture, as defined in section 147B.01, subdivision 3, only when provided by a licensed acupuncturist or by another Minnesota licensed practitioner for whom acupuncture is within the practitioner's scope of practice ... (Minn. Stat. § 256B.0625 Subd. 8f).
- "Acupuncture practice" means a comprehensive system of health care using Oriental medical theory and its unique methods of diagnosis and treatment. Its treatment techniques include the insertion of acupuncture needles through the skin and the use of other biophysical methods of acupuncture point stimulation, including the use of heat, Oriental massage techniques, electrical stimulation, herbal supplemental therapies, dietary guidelines, breathing techniques, and exercise based on Oriental medical principles. (Minn. Stat. § 147B.01 Subd. 3).

While acupuncture has been an accepted practice for millennia, starting in China and expanding to other parts of the globe, it has been relatively recently studied with Western research methods. The volume and quality of this research is limited but improving rapidly.

Coverage policies among other payers vary. Medicare and many other payers do not cover acupuncture. Among payers that do cover, policies pertaining to covered indications and limitations differ. A Google search revealed varying degrees of coverage offered by the following payers: Aetna, Blue Cross Blue Shield Minnesota, Health Net, HealthPartners, Medica, Oregon Health Plan, Prime West and United Health Care.

Several, usually small, studies on a wide range of indications show impressively high responses to acupuncture and the studies are also beginning to show cost-effectiveness in some circumstances.

Interestingly, many studies also show high responses to sham acupuncture particularly in the pain literature. The sham responses may be due to either or both of two factors. On the one hand, responses to pain are inherently subjective and there may be a large placebo effect. Equally plausible is that in some studies the sham acupuncture procedure may be stimulating patients' pressure points; in such studies, the sham response may more accurately be understood as weak acupressure. Unfortunately, the published studies do not tend to describe adequately the actual sham procedure so that we can discern a placebo response from a treatment response.

In considering whether and how to expand indications for acupuncture, we must weigh the risks and benefits of the procedure in comparison to risks and benefits of alternative therapies. For example,

when considering using acupuncture to treat pain, we should consider its risk/benefit profile in comparison to opioids or more invasive procedures.

Recommended approach for discussion:

The Veterans Administration's evidence maps of acupuncture literature (report dated 2014; literature pulled in early 2013; available at <http://www.hsrd.research.va.gov/publications/esp/acupuncture.pdf>) offers a useful starting point for discussion, supplemented by more recent research from the MED Project and presented during public comment. Given acupuncture's low risk and relatively low cost, DHS staff recommends covering indications that are shown to have an actual or potential positive effect, with a confidence level that is moderate or higher. In other words, start by covering the indications that are depicted by medium-to-large circles in either of the two columns to the right on the attached evidence maps. Within the VA's wellness and mental health categories, such indications are:

- Insomnia
- Smoking cessation
- Postoperative nausea and vomiting (PONV)
- Restless legs
- Depression
- Schizophrenia
- Anxiety
- Post-traumatic stress syndrome (PTSD)

In addition, DHS staff recommends coverage for cancer care-related nausea and vomiting, pregnancy-related nausea and vomiting, xerostomia and menstrual disorders, based on more current research available from MED and from public comment and expert presentations heard during recent HSAC meetings.

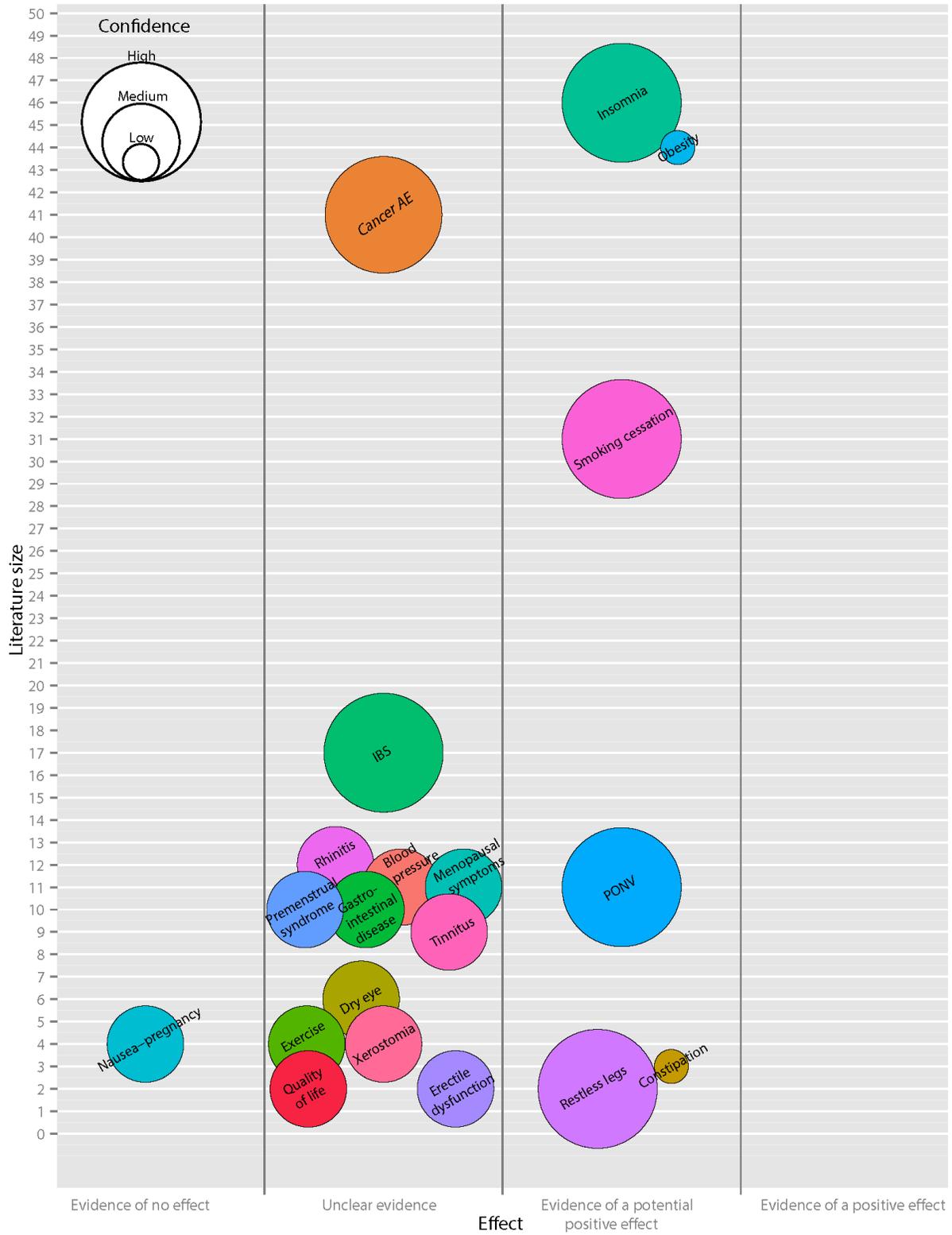
For pain, DHS staff recommends against parsing out the many different causes of pain and simply expanding coverage to include treatment of pain, both acute and chronic. While not all indications for pain have been studied adequately within the acupuncture literature, the potential for offering a safe alternative to existing, riskier therapies is compelling.

Thus, the full list of recommended indications for discussion is:

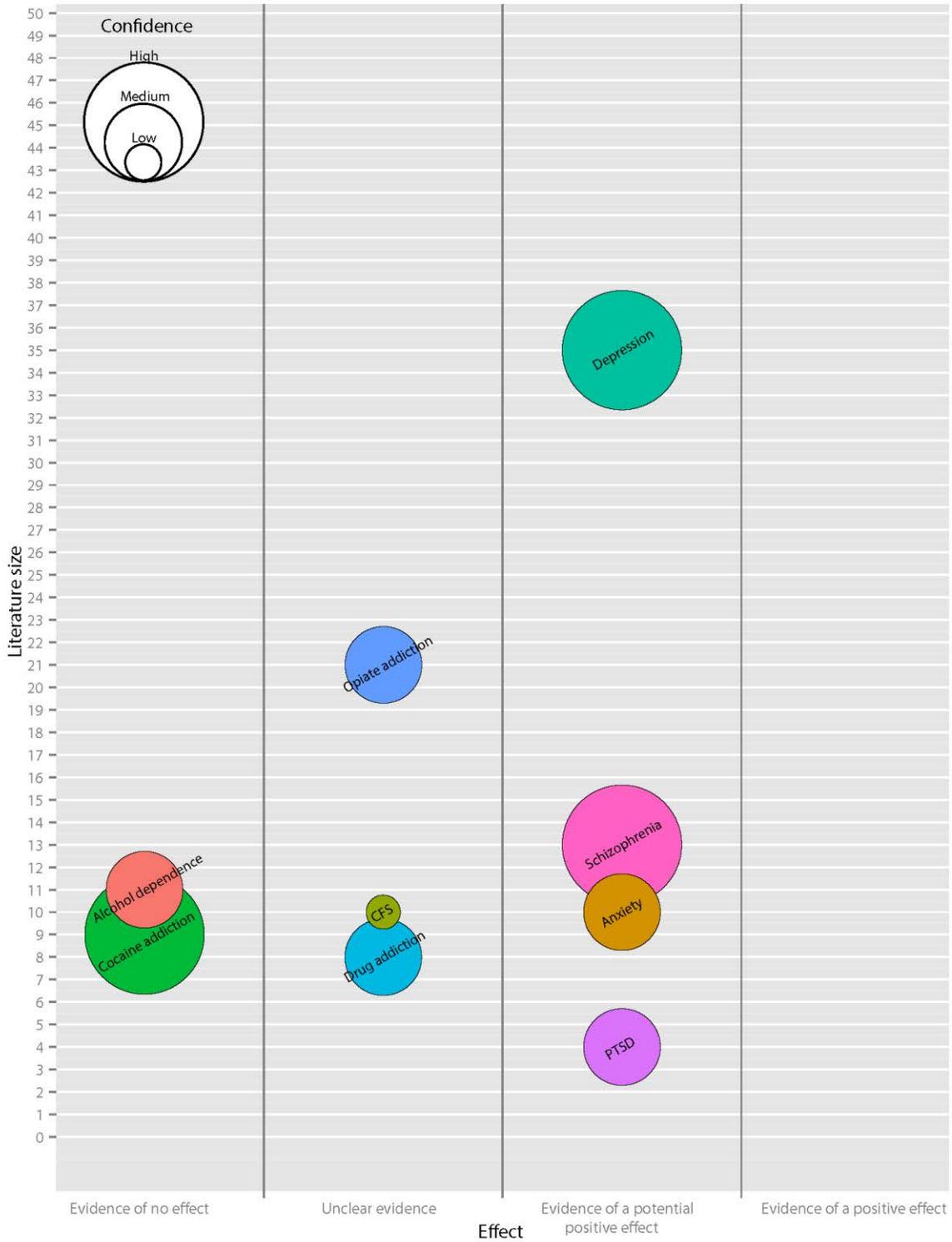
- Pain
- Insomnia
- Smoking cessation
- Nausea and vomiting (post-operative, pregnancy, cancer care)
- Restless legs
- Depression
- Schizophrenia
- Anxiety

- Post-traumatic stress syndrome (PTSD)
- Xerostomia (Sjogren's syndrome, radiation therapy)
- Menstrual disorders

Veterans Administration Evidence Map of Acupuncture for Wellness
 Available at <http://www.hsrd.research.va.gov/publications/esp/acupuncture.pdf>

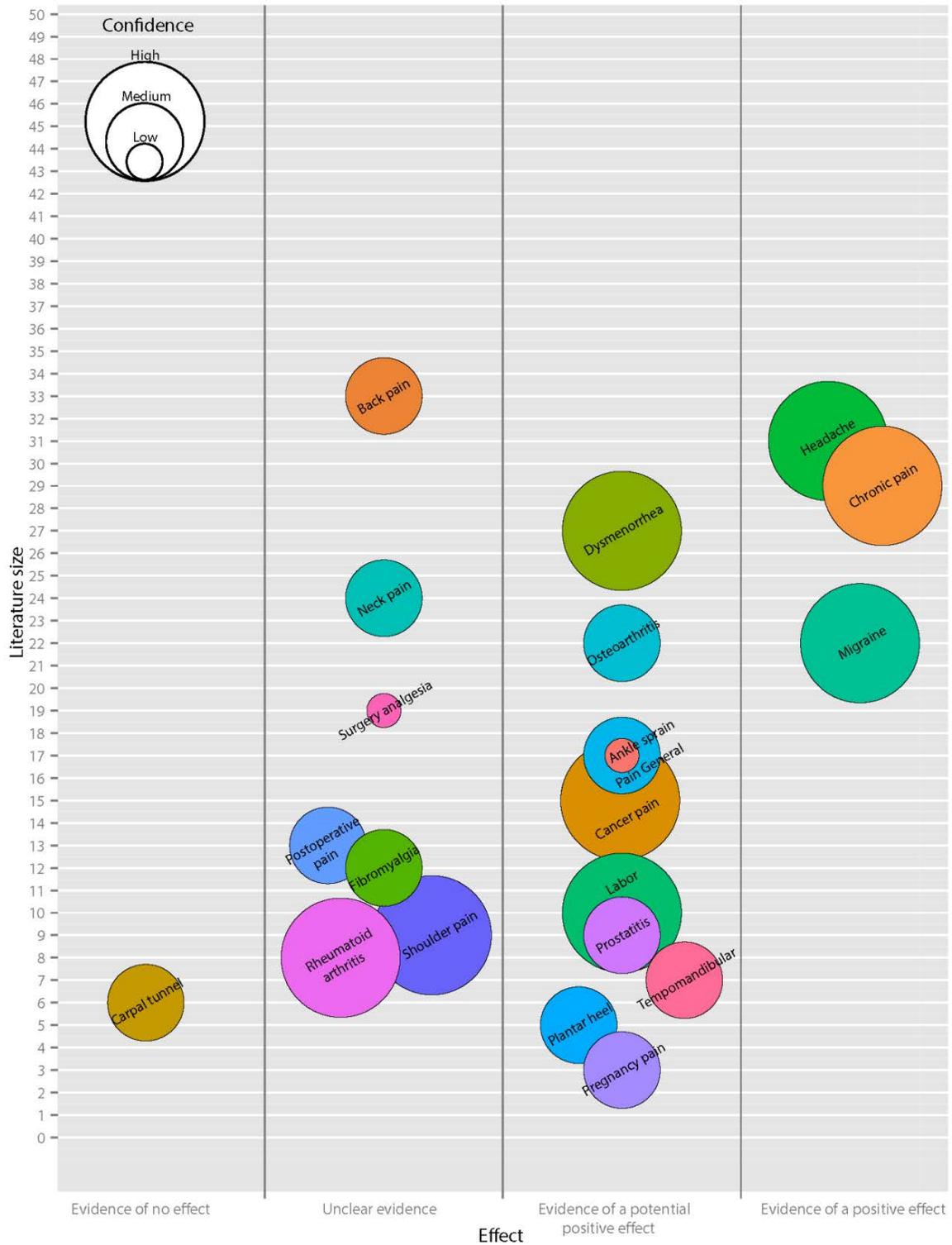


Veterans Administration Evidence Map of Acupuncture for Mental Health
 Available at <http://www.hsr.d.research.va.gov/publications/esp/acupuncture.pdf>



Veterans Administration Evidence Map of Acupuncture for Pain

Available at <http://www.hsrd.research.va.gov/publications/esp/acupuncture.pdf>





Health Services Advisory Council

Minutes — June 11, 2015
3:00 – 5:00 p.m.
Andersen Building, St. Paul

Members Present

Don Brunnquell, Amelia Burgess, Andrea Hillerud, Tamiko Morgan, Jeff Schiff (non-voting), Timothy Sielaff (chair), Cedric Skillon

Members Absent

Howard Fink, Lance Hegland, Patrick Irvine, Jim Miner, William Parham III, Katie Pieper

DHS Staff Present

Ellie Garrett, Deidre Jackson, Cheryl Newgren, Fritz Ohnsorg

Others Present

Jim Abeler (Acupuncture and Oriental Medicine Association of Minnesota), Courtney Baechler (Penny George Institute for Health and Healing/Allina Health), John Blaska, (Acupuncture and Oriental Medicine Association of Minnesota), Erin Huppert (Allina Health), David Kunz (Northwestern Health Sciences University), Michele Maiers (Northwestern Health Sciences University), Megan Odell (Penny George Institute for Health and Healing/Allina Health)

I. Welcome, introductions, updates and minutes

The chair, Tim Sielaff, welcomed members and guests to the meeting, and introductions were made around the room. No corrections were offered to the minutes, but approval of the minutes was postponed due to lack of a quorum.

Jeff Schiff provided the following updates:

- The legislature directed DHS to implement an opioid prescribing improvement program. A community-based work group will be formed to recommend key features of the program's design. The legislation calls for an HSAC member to be appointed to the new work group.
- The legislature also authorized funds for grants to support communities at disproportionate risk of adverse pregnancy outcomes within their populations. Part of the program will specifically address disparities in neonatal abstinence syndrome.
- Sielaff is serving on DHS' quality advisory work group.
- DHS is partnering with other state agencies and the US Attorney's office to convene a statewide summit in August on opioid prescribing and abuse.
- The July HSAC meeting will be rescheduled due to scheduling conflicts at DHS.

II. Presentations regarding acupuncture

A. Dr. Courtney Baechler, Penny George Institute for Health and Healing

Sielaff summarized HSAC's discussions to date regarding expanded indications for acupuncture. He introduced Dr. Courtney Baechler from the Penny George Institute for Health and Healing.

Baechler described the Institute's consultative approach for incorporating integrative medicine into hospital and outpatient care. She also summarized data demonstrating positive outcomes achieved (e.g., substantial decreases in pain and anxiety among patients with cardiovascular disease; decreased length of hospital stays; hospital cost savings associated with pain reduction). She also summarized key literature pertaining to acupuncture's safety and effectiveness to treat a wide range of indications. She recommended that at a minimum DHS expand coverage for acupuncture for the following indications:

- Migraines/headaches
- Nausea/vomiting (post-op, pregnancy, chemo)
- Post-operative pain
- Pain after dental procedures
- Cancer-related pain
- Osteoarthritis of the lower back and hips
- Xerostomia (Sjogren's, radiation therapy)
- Menstrual Disorders

A copy of Baechler's presentation is available [upon request](#).

Megan Odell, an acupuncturist from the Institute, joined Baechler at the podium to take questions. Discussion ensued. In response to questions, the speakers Baechler and Odell clarified that acupuncture offers cumulative results that generally begin to appear after one to four session and for most indications need about eight to 15 sessions to achieve full results. Most patients are treated once weekly. Provider location (whether inpatient or outpatient within the Allina system) makes little to no difference in outcomes.

1. Public comments

Michele Maiers observed that HSAC has received information about efficacy of acupuncture, much of which is inconclusive, and she asked Baechler for her perspective. Baechler stated that she couldn't speak to the literature given to HSAC, but stated that results at Allina are documented and establish effectiveness.

Maiers stated that the HSAC literature seemed skewed in favor of a few, limited authors who are acupuncture skeptics. She stated that other reviews, including one by the Veterans Administration, have a wider selection of literature and indications.

2. HSAC members' discussion

Members discussed gaps in scientific literature generally, and the tension between efforts to raise evidentiary standards generally while not holding some therapies, such as acupuncture, to unduly high scientific standards compared to other aspects of medical practice.

Schiff observed the need to contextualize the discussion and consider acupuncture's potential salutary effects on hospital length of stay or declined opiate use. In addition, if DHS expanded coverage for acupuncture then large amounts of data could become available to study these relationships.

Schiff asked the health plan medical directors who were present what their coverage policies were. Morgan reported that Metropolitan Health Plan is in the process of considering coverage for alternative therapies, and that she is particularly interested in data showing a relationship with reduced opioid utilization. Hillerud stated that Blue Cross Blue Shield of Minnesota currently covers acupuncture only to treat chronic pain.

B. Ellie Garrett, DHS

Garrett summarized discussions to date regarding acupuncture and explained HSAC's work plan for the topic. She then summarized the results of a MED Project literature review on acupuncture to treat acute pain. She explained that she'd asked MED to exclude literature on chronic pain, because DHS already covered acupuncture for chronic pain. The review was limited to a "review of scientific reviews" for clinically significant effectiveness and that were published in English within the last five years. MED identified seven good-quality scientific reviews, which collectively showed that the evidence of effectiveness is limited and that there are large sham responses to acupuncture. The sham responses might be due to placebo effect or might indicate that the sham intervention is really more active than placebo, because the sham intervention often pressure to an acupuncture site. Thus, the sham intervention might in some cases be mimicking acupuncture. The studies report subjective outcomes (like nearly all literature on treating pain). Nonetheless, patients participating in acupuncture studies to treat acute pain often report improvement. Garrett also drew members' attention to an evidence map illustrating the state of the evidence on acupuncture as of March 2013; the map was published as part of the Veterans Administration's Evidence-based Synthesis Program in January 2014. The map is available on the [Veterans Administration's website](#).

She summarized considerations for HSAC:

- Evidence is limited but growing
- Possible benefits of acupuncture compared to risks are high
- HSAC could consider recommending relatively open access to acupuncture, with continuation of treatment after a certain point in therapy conditioned on successful response to initial therapy
- Tracking of co-occurring therapies is possible

A copy of Garrett's presentation is available [upon request](#).

Sielaff departed the meeting early, and Schiff chaired the remainder of the meeting.

1. Public comments

John Blaska stated that acupuncturists have a wide scope of practice, and provide other interventions as are appropriate for individual patients. He urged that HSAC consider other modalities within acupuncturists' scope of practice.

Maiers commended HSAC's discussion and particularly recognition of acupuncture's role as an alternative to opioids. She cautioned against only covering acupuncture after failing other treatments, since acupuncture's benefits and safety warrant coverage as an initial therapeutic option.

Jim Abeler reported that he was pleased with the group's discussions and stated that HSAC's task was to recommend coverage for appropriate care. He hoped that all DHS enrollees would have access to acupuncture as needed.

Baechler stated that health care professionals have a responsibility to do no harm, and that more coverage should be available for therapies like acupuncture that are safe and offer benefit.

2. HSAC members' discussion

HSAC members' discussion ensued. Several members stated that they believed that coverage for acupuncture should be expanded. One member observed that better treatment for acute pain could help prevent chronic pain. Anything that can serve as an alternative to prescription pain medications is highly desirable, from the perspective of preventing substance abuse. Several members suggested that acupuncture be made available for the indications Baechler proposed. A member added that it would be useful to build the pool of data available for future study.

Schiff adjourned the meeting at approximately 4:55 pm.



Health Services Advisory Council

Minutes — April 9, 2015
3:00 – 5:00 p.m.
Andersen Building, St. Paul

Members Present

Don Brunnquell, Amelia Burgess, Howard Fink, Andrea Hillerud, Jim Miner, Tamiko Morgan, Katie Pieper, Jeff Schiff (non-voting), Cedric Skillon

Members Absent

Lance Hegland, Patrick Irvine, William Parham III, Timothy Sielaff

DHS Staff Present

Karen Dopson, Ellie Garrett, Susan Kurysh, Cheryl Newgren, Fritz Ohnsorg

Others Present

Jim Abeler (Acupuncture and Oriental Medicine Association of Minnesota), John Blaska, (Acupuncture and Oriental Medicine Association of Minnesota), David Kunz (Northwestern Health Sciences University), Charles Sawyer (Northwestern Health Sciences University)

I. Welcome, introductions, updates and minutes

In Tim Sielaff's absence, Jeff Schiff chaired the meeting. Once a quorum was present, **the minutes of the February HSAC meeting were approved without corrections.** Tamiko Morgan, MD, FAAP, medical director of Metropolitan Health Plan, was welcomed as a new HSAC member.

Schiff announced that the new, early intervention benefit for children with autism had received federal approval. He also announced that a National Governor's Association-supported summit on addressing the crisis of prescription opioid abuse and over-utilization is planned for late May. More details will be forthcoming. The Governor has two legislative proposals pending regarding opioids: an opioid prescribing improvement initiative and another pertaining to reducing and managing opioid exposure during pregnancy. His final announcement concerned the publication of a groundbreaking report on children's social risk factors, entitled "How prevalent are family risk factors among Minnesota children who receive Medical Assistance (MA) or MinnesotaCare?" A [news release](#) is available, as is the [full report](#) on DHS' public web site. (If the previous link to the full report does not open correctly, copy and paste it into your browser: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7079-ENG>.)

II. Final revisions and approval of recommendations for multidisciplinary chronic pain rehabilitation programs (MPPs)

Ellie Garrett summarized the draft recommendation that was distributed prior to the meeting. Discussion ensued. Schiff clarified that the recommendations called for outcomes to be reported using standardized instruments, but stops short of specifying which instrument(s) are required. A member observed that use of multiple tools would inhibit apples-to-apples comparisons. Staff will explore the logistics of standardizing some of the data requirements. Another member suggested that uniform baseline data also be obtained in order to assess improvement in a standardized way. Other HSAC members agreed. **A motion was made and seconded to adopt the draft recommendation, as amended to call for gathering baseline data using standardized instruments. The motion carried unanimously. A copy of the final recommendations, as amended, is appended to these minutes.**

III. Selection and initial discussion of indications for acupuncture

Garrett stated that DHS' goal for HSAC is to make recommendations regarding whether to expand acupuncture coverage to more indications, and if so, which. She proposed a work plan and initial indications for HSAC's consideration.

Proposed work plan:

- April
 - Introduce topic
 - Scope the work
 - Review evidence for using acupuncture to treat nausea and vomiting
- June
 - Acute pain
- July
 - Post-stroke depression
 - Breech presentation
 - Final recommendations

Staff recommended the above indications (nausea/vomiting, acute pain, post-stroke depression and breech presentation), because one or more payers cover the above indications, presumably after reviewing the evidence and concluding that it was strong enough to warrant coverage.

Garrett also summarized systematic reviews pertaining to the effectiveness of acupuncture to treat nausea and vomiting. The limited body of available evidence indicates that patients who receive acupuncture as a part cancer care experience better symptom relief for nausea and vomiting compared to usual care or no treatment. The evidence is less clear for post-operative and pregnancy-related nausea and vomiting. A copy of the presentation is available [upon request](#).

The chair welcomed public comments.

Jim Abeler, a representing the Acupuncture and Oriental Medicine Association of Minnesota (AOMAM), spoke first. Abeler disclosed that he was present as a paid lobbyist, but had no other disclosures:

He stated that acupuncture treatments add value to patients' lives. Many patients find relief through acupuncture after exhausting alternatives. Most diagnoses in the ICD-9 manual can benefit from alternative therapies. Acupuncturists want the opportunity practice the care that they are trained to do. Research shows that addition of acupuncture actually saves money in the end. He stated that DHS must decide out how to cover acupuncture more broadly, because state law requires coverage that is more expansive. Acupuncture should not be subjected to more scientific scrutiny than is the rest of medical care, much of which is not evidence-based. He stated that HSAC's consideration of acupuncture is a golden opportunity for the community, and he expressed his willingness to spend time as needed to help the dialog move forward.

A member asked if Abeler had any studies demonstrating acupuncture's cost-effectiveness, and he replied affirmatively. Abeler volunteered to circulate such studies after the meeting.

Charles (Chuck) Sawyer spoke next. Sawyer is a doctor of chiropractic and senior vice president at Northwestern Health Sciences University. He had no financial disclosures.

Sawyer spoke of the need for care coordination between practitioners of different disciplines. He stated that acupuncture is a high-touch, time-intensive encounter with demonstrated effectiveness, high patient satisfaction and low cost. Acupuncture is safe, with only very rare side effects; he stated that the therapy has no downside. He stated that there is a strong argument for treating patients early with acupuncture, especially for patients who are not good candidates for alternative therapies.

John Blaska is a doctor of acupuncture and oriental medicine, representing AOMAM. He had no financial disclosures.

Blaska stated that acupuncture is effective when diagnoses are accurate. It is used in 80% of the world, and it is time to integrate acupuncture into health care in the US. He stated that research at Allina demonstrates acupuncture's cost-effectiveness. The body of evidence supporting acupuncture, while poor initially, has improved greatly.

In response to a member's question, Blaska explained that acupuncture is guided by standard protocols for general categories of care, which are then individualized for each patient.

Following the public comment period, the chair permitted an open dialog among HSAC members and guests. The discussion turned to indications in general and how best to scope the literature regarding acupuncture. After discussion, HSAC members and guests generally agreed that the best approach is to proceed as planned by discussing indications by symptom category (e.g., acupuncture to treat nausea and vomiting), though some literature may also break down by diagnosis rather than symptoms. Garrett noted that the search for literature on nausea and vomiting revealed studies and systematic reviews that were more specific, e.g., literature on pregnancy-related or chemotherapy-related nausea and vomiting. Starting with a general search and then seeing where the literature leads is reasonable.

Schiff observed that HSAC's challenge is to review the quality and sufficiency of the evidence. In response to a question, he clarified that HSAC often considers studies performed outside of the US when the body of domestic literature is lacking and so long as they were published or translated into English; the issue is not where a study was conducted but whether it was conducted well and without bias.

Garrett queried whether HSAC wished to proceed as staff recommended, focusing on acute pain at the next meeting. Members generally agreed with so doing.

The chair adjourned the meeting at approximately 5:00 p.m.

Recommended criteria for covering multidisciplinary, comprehensive, non-procedural and non-opioid based chronic pain rehabilitation programs (MPP)

1. Patient selection (medical necessity) criteria
 - a. Duration of pain at least four months with associated loss of functional capacity
 - b. Physician referral, accompanied by attestation of completion of appropriate medical evaluations, the purpose of which is to confirm that any underlying physiological causes of the pain have been identified and appropriately treated
 - c. Willingness to forego instituting or continuing interventional procedures
 - d. Willingness to wean from opioid and benzodiazepine products
 - e. Completion of substance use disorder (chemical dependency) treatment as needed
 - f. Willingness of relevant family or care partner to participate in therapeutic process
 - g. Ability to manage activities of daily living sufficiently to allow participation in the program
 - h. Ability to participate in group therapy, including absence of psychotic, self-injurious, or aggressive behavior
 - i. Failure of appropriate unimodal treatment programs
2. Baseline and post-treatment evaluation requirements
 - a. Functional status (using standardized measurement instruments)
 - b. Depression, anxiety, pain catastrophizing scores (using standardized measurement instruments)
 - c. Review of relevant medical record
3. Multidisciplinary program components
 - a. Delivered in group setting
 - i. Aerobic physical activity
 - ii. Strengthening and flexibility
 - iii. Occupational therapy
 - iv. Behavioral – cognitive behavioral therapy
 - v. Education
 - vi. Family or care partner involvement
 - b. Delivered individually
 - i. Opioid/ benzodiazepine weaning
 - ii. Appropriate medical management (e.g., anti-anxiety or anti-depressant medications)
 - iii. Appropriate continuation or initiation of individual therapy to address co-morbid behavioral health conditions
 - c. Appropriate intensity and dosing, with programming lasting 3 – 5 half to full days per week, delivered for 3 – 4 weeks
4. Program structure and functioning
 - a. Single primary physical site

Revised and adopted by HSAC on April 9, 2015

- b. Coordinated team approach among all therapists and clinicians
- c. Cognitive behavioral/educational orientation and training for all therapists/staff/clinicians
- d. Internal quality improvement processes
- 5. Outcome documentation and follow up
 - a. Rates of program completion
 - b. Discharge objective reevaluation
 - i. Evaluation of functional status and concomitant behavioral health diagnoses (depression/anxiety) using standardized measurement instruments, compared with baseline measures prior to commencement of treatment
 - ii. Measures of patient's utilization of opioids and benzodiazepines, as verified through the Minnesota Prescription Monitoring Program
 - c. Discharge communication with referring providers
 - d. Follow up evaluation protocol at 9 – 12 months
 - e. Mechanism for follow up support (referral or internal)

Health Services Advisory Council



Minutes — February 12, 2015
3:00 – 5:00 p.m.
Andersen Building, St. Paul

Members Present

Don Brunnquell, Howard Fink, Patrick Irvine, Lance Hegland, Andrea Hillerud, Jim Miner, Katie Pieper
Jeff Schiff (non-voting), Timothy Sielaff (chair), Cedric Skillon

Members Absent

Amelia Burgess, William Parham III

DHS Staff Present

Jeanne Fromholz, Ellie Garrett, Judy Gunderson, Susan Kurysh, Cheryl Newgren, Fritz Ohnsorg

Others Present

Paul Heideman (MAPS), Murray McAllister (Courage Kenny Rehabilitation Institute/Institute for Chronic Pain), Judy Rowland (Actavis)

I. Welcome, Introductions, Updates and Minutes

Tim Sielaff called the meeting to order, and members, staff and guests introduced themselves. **The minutes of the October HSAC meeting were approved without corrections.**

A. Legislative Updates

Jeff Schiff updated HSAC on three of the Governor's legislative proposals. First, acting on recommendations from HSAC and others in the community, the Governor's proposal includes an opioid prescribing and monitoring initiative. Second, the Governor proposes improving birth outcomes for high-risk women by addressing the two largest risks to healthy births—opioid use and low birth weight. In Minnesota, these two risks are concentrated in minority populations and have resulted in persistent, recalcitrant health disparities. Third, the governor's budget recommends implementation of the behavioral health home model, improving access to coordinated delivery of primary care and behavioral health services. This proposal will serve adults and children with serious mental illness, serious and persistent mental illness, and children and youth with severe emotional disturbance.

B. Other updates: HSAC vacancy

Ellie Garrett reported that Dr. Alvaro Sanchez had resigned from HSAC due to a change in employment. His seat was one that the Legislature designated to a physician representing a health plan contracted to serve Minnesota Health Care Program recipients. The deadline for applying is February 26.

Information about how to apply is available on the Minnesota Secretary of State's list of February vacancies.

II. Multidisciplinary Chronic Pain Rehabilitation Programs

Sielaff drew members' attention to the meeting goal as stated on the agenda: To discuss the topic of Multidisciplinary, comprehensive, non-procedural and non-opioid based chronic Pain rehabilitation Programs (MPPs), leading to recommendations regarding coverage, provider standards and patient selection criteria.

Garrett summarized findings from two recent literature reviews performed by Oregon Health Science University researchers via the MED Project. The first review concerned treatment for adults, and the second children. Copies of her slides were circulated to the HSAC distribution list (and remain available [on request](#)), as were citations to all of the articles highlighted in the reviews.

Highlights and conclusions of the studies and reviews pertaining to adults include:

- The literature comprises a heterogeneous evidence base of moderate to low quality studies, with varied modalities, intensity, populations, comparators, follow-up
 - Most studies concern or have a high percentage of participants with low back pain.
 - MPPs are likely to be more effective than usual care at reducing pain intensity, disability, and number of sick days, and increasing quality of life and return-to-work likelihood compared to usual care. Definitions of “usual care” varied and often were not well described.
 - There is scant evidence on MPP characteristics (e.g., treatment intensity, staffing and use of treatment modalities) regarding MPP effectiveness. Studies varied in structure, staffing, and intensity of services.
 - There are no reported harms of MPPs in the literature.
 - Limited evidence suggests that MPPs may be cost-effective at reducing sick absences and increasing return-to-work status. There is insufficient evidence to determine the cost-effectiveness of MPPs for other outcomes.
- Despite variances, the vast majority of the studies report some magnitude of beneficial effect from MPPs for individuals with chronic pain.

Highlights and conclusions of the studies and reviews pertaining to children include:

- MPPs have not been widely studied in children
 - Prior to 2014, 3 good-quality and 5 poor-quality case series, mostly in Europe
 - 2014, good-quality RCT in Germany (intensive inpatient MPP; 3 weeks, 5 – 8 hours/day)
- There is moderate strength of evidence showing that MPPs improve pain, disability and school attendance over short-term (3 – 4 weeks).
- There is low strength of evidence showing that MPPs improve pain, disability, coping and school attendance longer term (12 months)
- There are no cost-effectiveness studies, though several authors commented on economic benefits of reduced provider and ED visits and parent absences from work.

Brief discussion ensued, and Schiff drew the members' attention to a handout, "draft criteria for recommending coverage of multidisciplinary, comprehensive, non-procedural and non-opioid based chronic pain rehabilitation programs." The handout was circulated in advance of the meeting to everyone on HSAC's distribution list. Comments included:

- Uniform outcomes data that would support comparisons across programs would be useful.
- Post-service audits or "gold card" advance approval of the small number of MPP providers should be considered.
- Rural clients could be reimbursed for transportation and lodging to and from the limited number of providers based primarily in the Twin Cities. Telemedicine could expand access to after-care.
- The duration of pain requirement (3 – 6 months) might need to be adjusted downward, to allow earlier access to rehabilitation.
- Programs report success with weaning patients off opioids, though patients unwilling to consider weaning choose not to enter the programs. The VA requires patients to taper down to <150 mg morphine equivalents daily prior to admission to the VA's new MPP. Thus far, all but one VA patient has been weaned off opioids within the MPP program, and that patient weaned off thereafter.
- MPPs in Minnesota are too small and the programs are too intensive for the vast majority of pain patients. Pain treatments across the board, and particularly in primary care settings, need to be reconsidered.
- In response to a question from an HSAC member, Murray McAllister stated that Courage Kenny's MPP probably would not accept patients who are simultaneously receiving medication-assisted therapy (MAT, e.g., methadone or buprenorphine) to treat opioid abuse disorder. Paul Heideman stated that MAPS sees very few patients who are on MAT.
- The requirement for family or care partner participation is important for treatment success, though some concern was expressed about patients who lack familial support. A member stressed the importance of patients having the support of someone—whether family member, friend, spiritual advisor, or other close contact—to participate with them. The phrase "family or care partner" was deemed acceptable.
- In response to a question, McAllister and Heideman both stated that "bounce back" treatment rates are low. When patients decide to leave treatment early and then return later to treatment, it is generally due to factors out of their control, such as an injury or an illness in the family.

A motion was made and seconded directionally to endorse the draft criteria, pending revisions. The motion carried unanimously. Schiff stated that staff would revise provisions 1(a), 1(e), 3(a)(vi) and 5(d) in particular. Staff will circulate an updated version for HSAC's approval either via email or at the next HSAC meeting. In response to a question, McAllister clarified that all of the cognitive behavioral therapy that is directed toward pain management is provided in group settings; individual therapy for co-morbid conditions is provided as needed. Heideman clarified that individual therapy may also be used when crises arise during a patient's participation in the program.

In response to a question about cost, McAllister suggested that outpatient therapy costs in the range of \$10,000, and inpatient or residential therapy can be double that.

Garrett observed that section 1(c) of the draft criteria might need to be revised. The goal is not to push potential patients toward exhausting procedures but rather to make sure that patients are diagnostically appropriate candidates for an MPP and sufficiently motivated toward full participation in the MPP.

A member closed the meeting by commenting that many participants in the restricted recipients program might be good MPP candidates.

The meeting was adjourned at approximately 4:40 p.m.