

Opioid Prescribing Work Group

Minutes — November 16, 2017

noon – 3:00 p.m.

444 Lafayette Building, St. Paul

Members present: Julie Cunningham, Chris Eaton, Tiffany Elton (remotely), Dana Farley (non-voting), Rebekah Forrest, Ifeyinwa Nneka Igwe (remotely), Brad Johnson, Chris Johnson, Ernest Lampe, , Matthew Lewis (remotely), Pete Marshall, Murray McAllister, Richard Nadeau, Mary Beth Reinke (non-voting), Charlie Reznikoff, Jeff Schiff (non-voting), Charles Strack, Lindsey Thomas

Members absent: None

DHS employees: Titi Adeniyi, Charity Densinger, Maisha Giles, Dave Hoang, David Kelly

Guests: Hanna Anderson (Century College), Kira Bork (Weber), David Campbell (Century College), Jim Cook (Mercer), Seth Hartman (Century College), Juliana Milhofer (MMA), Blair Orr (Depomed), Tyler McMahon (Century College), Trudy Ujdur (Sanford), James Schusterich (Century College), Kelley Waara-Wolleat (Purdue), Lisa Wichterman (DLI), Kaylan Wilson (Pfizer Medical Affairs)

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 informed the work group that the governor's administration is currently working on an opioid legislative package for the next legislative session. The package includes an opioid stewardship proposal, also known as the "penny a pill" proposal. Schiff also thanked the opioid data team for their hard work preparing for this OPWG meeting.

Sarah Rinn provided two updates. First, Department of Human Services (DHS) Commissioner Emily Piper extended the authority of the OPWG through December 2019. OPWG members who wish to continue their service will need to apply for the second term. Second, Commissioners Ehlinger (Department of Health) and Piper (DHS) will be briefed next week on the opioid prescribing recommendations. The recommendations must be approved by both commissioners in order to be final. Rinn informed the group that there are tentative plans to hold a press conference to release the opioid prescribing guidelines at the beginning of December. The press conference will announce the guidelines, and open a 30 day public comment period.

Approval of Minutes and Opportunity for Public Comment

Members unanimously approved the September meeting minutes.

No public comments were offered.

Agenda and Overview

Rinn reviewed the agenda and the instructions for submitting a public comment. A copy of the slides is available upon request to DHS Opioid staff.

Members briefly reviewed the condensed provider groups for the index opioid prescription and the initial opioid prescribing episode measures. The specialty groups were condensed into the following groups: dental; emergency medicine, primary care-adult, medical specialists, OBGYN, surgical specialists, orthopedic surgery, other PA-APRN, and other/missing. A member asked whether the orthopedic surgery group includes both physicians and mid-level providers with an orthopedic surgery specialty designation. DHS confirmed that it does.

Index Opioid Prescription Measures: Data Review

DHS staff proposed reviewing all of the data for the index opioid prescriptions measures, and then discussing the quality improvement threshold for each measure. The work group began with reviewing the data for the index opioid prescription frequency measure. This measure is the total number of index opioid prescribing per the total number of distinct enrollees seen during the measurement year per provider. Members reviewed the median rate for each provider group, and then focused on specific rates within the fourth quartile of prescribers, by specialty group. Discussion ensued about the fact that the ceiling rate for all provider groups was 1.0. This rate indicates that the clinician prescribed an index opioid prescription to every distinct enrollee seen during the measurement year. Members and DHS staff discussed possible explanations for this data, including: providers with a rate of 1.0 likely had very few Medicaid enrollees in their patient panel; and prescribed a low volume of index opioid prescriptions. DHS staff shared that a sub-analysis for providers in the fourth quartile found that over half of the providers wrote 1 to 10 index opioid prescriptions in the measurement year.

Members then reviewed the data for the recommended dose measures for index opioid prescriptions. This measure is the number of opioid prescriptions that exceed the recommended dose per the total number of index opioid prescriptions. The recommended dose for non-surgical provider groups is 100 MME, and the dose for surgical provider groups is 200 MME. Members discussed the fact that many prescribers are writing over 100 MME for an index opioid prescription. In primary care, at least 1/8 of all primary care providers are always writing over 100 MME for an index opioid prescription. Next, members reviewed the data for 200 MME recommended dose measure. A member asked whether the intent of this measure is specifically to capture the post-operative prescription or if it meant to capture general surgical care. For example, someone may receive a month of opioid pain relievers for the month before a major orthopedic surgery. If the surgeon prescribes the opioids, it will be captured in this measure. DHS staff commented that the defining criteria for the measure is that person was opioid-naïve prior to the prescription, but that the intent of the recommendation is about prescribing following a severe acute event, i.e. surgery. A suggestion was made to include language about the intent of the measure in the prescriber report.

Schiff reminded members that the recommendation to prescribe no more than 200 MME following a major surgery or trauma is intended to cover the index opioid prescriptions. The recommendations indicate that if additional opioid analgesia is needed following the initial prescription, then the expectation is that the prescribed will begin to screen for mental health conditions, history of substance use, and risk factors for

chronicity. A member asked whether DHS will have the capacity to share patient id numbers with that patient's prescribers so that providers are able to correct specific instances of overprescribing or inappropriate prescribing. DHS staff indicated that it has not been considered yet, but it could be discussed at a later time.

A brief discussion ensued about the availability and quality of evidence that supports reducing post-operative opioid doses and duration. Members acknowledged a solid evidence base for dental procedures, and that an increasing amount of evidence is available for other surgical procedures. Richard Nadeau shared current data that oral surgeons have been able to reduce opioid prescribing by 60%. Julie Cunningham shared information about the work being done at Mayo to reduce post-operative prescribing. Mayo surgical departments have also been able to decrease prescribing by approximately 70%.

Discussion then turned to the nature of the patient's relationship to the provider, and some of the challenging legal implications of the guidelines. Members briefly discussed the provider's duty to the patient, and the potential for harm due to both overprescribing opioids and insufficient pain management.

Index Opioid Prescription Measures: Quality Improvement Threshold

Index Opioid Prescription: Recommended Dose Measures

Upon completion of the data review, the work group began discussion of the quality improvement thresholds. Schiff clarified that the goal is to determine a threshold that once exceeded will prompt a mandatory quality improvement review with an individual prescriber. A recommendation was made to set the threshold for the non-surgical dose recommendation measure (100 MME total) at a frequency of 0.50 or 50%. Prescribers who write for more than 100 MME total in more than 50% of their index prescriptions would exceed this threshold. Members discussed the implications of the threshold. It is well documented in the data that many providers routinely write more than 100 MME for an index opioid prescription, so for some providers this requires a significant change behavior change. A member questioned creating a goal of 50% compliance, given that when other clinical guidelines are released the expectation is full compliance. A member responded that it could partly be explained by the nature of the patient-provider relationship during this pain phase. Often the physician and patient do not have an existing relationship, and there is no obligation to continue prescribing after the initial prescription (unlike chronic). Members considered how the threshold may evolve over time. It is possible that as the number of unnecessary opioid prescriptions decrease and providers comply with the dose and duration recommendations, the proportion of high-dose index opioid prescriptions prescribed for major tissue damage will increase. That will make those providers the outliers, and the state needs to be prepared to address those kinds of shifts. Schiff commented that some of this can be addressed by the special cause variation permissions.

A brief discussion ensued about whether providers who prescribe at a low frequency should be excluded from the quality improvement efforts. The group agreed to table that consideration for the time being, so that the state is able to better understand the data and how that exclusion could be applied.

A motion was made to adopt 0.50 as the threshold for participation in a quality improvement progress for non-surgical specialties for the index opioid prescription recommended dose measure. The motion was seconded, and the motion was approved unanimously.

Members discussed implementation of the standard, and whether there is a mechanism for providers to gauge their compliance. Possible mechanisms mentioned included more frequent reporting or creating a system log. Several members commented that compliance with this measure also depends on providers re-educating themselves around a standard prescriptions that is less than 100 MME. Many providers also have Electronic Health Records (EHRs) that are able to calculate MME in the system, and another option is a self-audit of the PMP. A few members continued to express concern about how providers will be able to track their compliance with this threshold.

Members turned to the recommended 200 MME dose measure for surgical specialties. A proposal was made to apply the same threshold for quality improvement—0.50—to the surgical specialties. The proposed threshold will be a significant ask for certain specialties, e.g., orthopedic surgeons. A member asked with the 200 MME limit is consistent with the work being done in health systems around post-operative prescribing. A member shared that post-operative prescribing recommendations developed for Mayo are based on levels of acuity for pain anticipation. The maximum level of acuity corresponds to a recommended dose of 300 MME. Two concerns related to post-operative prescribing measures is that post-operative patients are not really opioid naïve, and that there are a group of surgeons who only perform complex, major surgeries. Surgeons who only perform major surgeries will need to self-identify themselves, and this will be a consideration for a special cause variation. Schiff reminded the group that the guidelines do not prohibit surgeons from prescribing a higher dose or duration of post-operative opioids with a second prescription, but then there needs to be increased risk assessment to reflect the elevated risk of harm presented with bigger prescriptions.

A motion was made to adopt 0.50 as the threshold for participation in a quality improvement progress for surgical specialties for the index opioid prescription recommended dose measure. The motion was seconded, and the motion was approved unanimously.

Index Opioid Prescription Frequency Measure

Members then returned to the index opioid prescription frequency measure to discuss the quality improvement threshold. The challenges presented by this measure is that the rate of prescribing is more sensitive to unique aspects of individual practice than the amount (dose) prescribed, and that there is less evidence about an appropriate rate of prescribing. Given these challenges, an appropriate approach to the threshold is based on peer comparison within specialties. The group briefly discussed whether it is appropriate to set one rate for all specialties, or whether the thresholds should be tailored by specialty. For example, surgeons are likely to have a higher rate of prescribing given the need for appropriate pain control following surgical procedures. Members also discussed removing the low volume prescribers, but no consensus was reached.

Discussion then turned to creating a quality improvement (QI) threshold for a limited number of provider groups. The group agreed that the QI process should target the specialties where there is concern about the variation in prescribing behavior. DHS staff reminded the group that this is the first year of reporting, so that there will be an opportunity to better understand what the data looks like on an individual level prior to implementing the QI process. Members discussed that the frequency measure may identify outliers in specialty groups where the amount (dose) of opioids is fairly consistent, e.g., emergency medicine and dentistry.

An initial vote was taken of the group about whether there should be a standard for frequency of prescribing for the purpose of QI for any groups of prescribers in the first year. The group unanimously voted yes.

A second vote was taken to identify which specialties should have a standard threshold for QI in the first year. The group discussed various options: medical specialties versus surgical specialties, identifying specialties based on the intra-specialty variation, specialties whose practice type is indicated or not indicated for opioids. The group unanimously voted in favor of applying a standard threshold for QI for the medical specialty provider groups.

A third vote was taken to create a quality improvement threshold for non-surgical specialties in the first year, based on frequency of prescribing. The group unanimously voted yes.

A fourth vote was taken to not create a quality improvement threshold for surgical specialties in the first year, based on frequency of prescribing. The group unanimously voted yes.

The group then reviewed the frequency of prescribing an index opioid prescription data. Members commented that the standard should err on the side of leniency in the first year of reporting. The group identified that the median rate of prescribing in the fourth quartile for a number of medical specialties is 8% (Of all medical specialty providers, 83% (7/8) wrote for opioids in less 8% of unique individuals seen in the measurement year.)

A fifth vote was taken to use 8% as the standard threshold for quality improvement for medical specialty groups. The group voted yes, and no members presented any objections.

Several member commented that it is important that we pay close attention to the Physician Assistant (PA) and Advanced Practice Registered Nurse (APRN). If many instances the mid-level provider is a surrogate prescriber for a physicians, so it is important that we place the PA-APRN in the appropriate specialty group.

Chronic Pain Video

The work group viewed a video about chronic pain, produced by a research group based in Australia. The video is available [here](#). Julie Cunningham initially shared the video with DHS as a resource. The video was reviewed at Mayo, and has been incorporated into the various resources used to educate patients. Members suggested sharing the video with Weber Shandwick to inform the prescriber education campaign.

A brief discussion ensued about the group that produced the video, and the need for an overall paradigm shift in how the community approaches chronic pain. Not only is a culture shift needed about how opioids are used to manage pain, but an accompanying shift is needed in to treat chronic pain as a chronic disease. This will help reframe how we approach chronic pain management, using a rehabilitative approach rather than maintaining the immediate relief mentality perpetuated by interventions, procedures, and opioid therapy.

Meeting adjourned.