

Opioid Prescribing Work Group

Minutes — February 21, 2019

noon – 3:00 p.m.

444 Lafayette Building, St. Paul

Members present: Tiffany Elton, Dana Farley, Rebekah Forrest, Chris Johnson, Ernest Lampe (non-voting), Matthew Lewis, Pete Marshall, Murray McAllister, Richard Nadeau, Charlie Reznikoff (remotely), Jeff Schiff (non-voting), Charles Strack

Members absent: Julie Cunningham, Chris Eaton, Ifeyinwa Nneka Igwe, Brad Johnson, Mary Beth Reinke (non-voting), Lindsey Thomas

DHS employees: David Kelly, Sarah Rinn

Guests: Amber Bullington (Chronic pain patient), Audrey Hansen (ICSI), Diane Kelley (Chronic pain patient), Mary Kuna (KK&Co), Cammie LaValle (Don't Punish Pain), Juliana Milhofer (MMA), Cara Schulz (Burnsville City Council), Trudy Ujdur (Sanford)

Welcome and Introductions

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

DHS Updates

Jeff Schiff provided a brief update on two opioid-related issues. First, two companion opioid stewardship bills are under review in the state legislature. DHS staff analyzed the bills and provided input to encourage alignment with the OPIP. Second, the deadline for the federal State Opioid Response (SOR) grants was February 19. The SOR grant provides MN with over \$15m over two year period to expand access to treatment. DHS received a significant number of responses, especially in the care integration, recovery and innovation categories.

Schiff acknowledged the absent OPWG members attending the HMCM and MHA-sponsored Buprenorphine Boot Camp in St. Paul.

Sarah Rinn reported that the state is on track to launch the prescriber education campaign within 2-3 weeks. The first round of opioid prescribing reports are on track to release in late March or early April.

Approval of Minutes

Members unanimously approved the January 2019 meeting minutes.

Sarah Rinn reviewed the agenda for the webinar. A copy of her presentation is available upon request.

Opportunity for Public Comment

Cara Schulz (Libertarian Party representative, Burnsville City Council) provided public comment. Ms. Schulz expressed her concern that the Opioid Prescribing Work Group does not include a chronic pain patient representative. She also commented on a number of ways in which the OPIP represents government interference with medical practice, and that the program is effectively making the Centers for Disease Control and Prevention (CDC) guidelines mandatory in Minnesota. She expressed concern that the program will unfairly disenroll providers who treat Medical Assistance and MNSure patients, limit providers ability to care for pain patients, and devalue individualized patient care. Schulz's comment then turned to how the program is negatively impacting cancer patients, resulting in untreated pain and medical conditions. She cautioned that the program will increase the rate of suicide in the state, and force patients to hide risk factors from their health care providers in order to receive pain medication.

OPWG members expressed concern about the content of Ms. Schulz's claims. Time did not allow DHS staff to address the factual errors in her comments, but the errors will be addressed during the March OPWG meeting.

Amber Bullington provided public comment. Ms. Bullington stated that she does not support the quality improvement program. However, if it is implemented, guidance about tapering patients off of long-term opioid therapy is missing. She commented that there is a lack of knowledge among primary care providers about the tapering process and how to taper patients safely. She also commented on the need to stop talking about the opioid crisis as a prescription drug program. By not recognizing the role of illicit and synthetic opioid use in the population, we are harming the public health messages.

Quality Improvement Program Process

Rinn reviewed the proposed schedule for the OPIP quality improvement program. A copy of her presentation is available upon request. Discussion ensued about the number of QI thresholds that a provider must exceed in order to be required to participate. DHS staff commented that providers who are over at least one QI threshold will be required to participate. However, by considering both the QI threshold and the volume threshold, DHS can focus resources on providers with high rates and high volumes. Members then reviewed the January discussion and decision to tier participation requirements in the quality improvement program using prescription volume (acute and post-acute measures) or patient volume thresholds (chronic measures). A member of the public asked how many of the prescribers are caring for intractable pain patients. DHS staff responded that this is not part of the data analysis. Any information about a specific provider's patient panel will be addressed as part of the attestation form and quality improvement process. A member asked whether this information only goes to the provider, and Rinn responded that the statute permits the agency to inform the provider's affiliated employers if the provider is over the QI threshold.

DHS staff provided an overview of the quality improvement program process. In general, providers who exceed a quality improvement threshold for a given measure and who prescribed a certain volume of opioids during the measurement year must participate. Participating providers will receive an attestation form, which will include specific quality improvement activities and processes. Providers will be given 5-6 months to attest that those policies or practices are in place, and to provide clinic policies or data when needed.

Tier 1 acute/post-acute pain

Discussion ensued about the proposed process for Tier 1 acute and post-acute pain quality improvement. DHS staff informed members that the specific activities will be addressed in the next agenda item, and that the task is to review the process. A brief discussion ensued about including registering for the PMP on the attestation form, given that it is a state requirement. DHS staff responded that recently registration was approximately 30%, so there is room for improvement. Discussion ensued about the process of submitting the form, and members agreed to hold questions about specific activities until the next OPWG meeting. A member asked about the disenrollment process, citing concern that failure to attest to activities in the Tier 1 Acute and Post-Acute Pain section did not seem commensurate with disenrollment. DHS responded that there is significant work to be done on the disenrollment standards. The disenrollment thresholds will be based on the sentinel measures, but the thresholds and criteria for disenrollment will likely be very different. Another question arose about what will constitute clinic policy and health system documents. A member commented that within their own health system, there is a lot of variation in processes.

Tier 2 acute/post-acute pain

DHS staff and members reviewed the process for providers flagged for Tier 2 Acute and Post-acute pain quality improvement. A member commented that the specific content within the tables is critical. He cautioned that we need to carefully think about what we want to achieve, and take precautions that the QI process does not result in providers inappropriately withholding opioids after acute events.

Chronic pain

DHS staff and members then reviewed the process for providers flagged for quality improvement participation based on the chronic pain prescribing measures. Comments and questions about specific activities were held for discussion.

Special cause exemption

Discussion turned to the special cause exemption request process at the bottom of the attestation form. DHS staff proposed a process by which providers who request an exemption will still have to attest that specific QI activities are performed in their practice. A member asked how providers granted special cause exemption will be managed from year to year. A brief discussion ensued about using the data provided to monitor patient safety and patient stability. Discussion briefly turned to concerns that cancer patients are being included in the quality improvement efforts. Audrey Hansen (ICSI) shared that ICSI staff have found that cancer patients who are now on palliative care are being mistakenly treated as opioid naïve, or as never having had cancer. Providers in different settings are missing the fact that they receive palliative care. Schiff responded that one of the goals of OPIP is to create a structure that addresses unsafe prescribing and allows for appropriate variation.

Discussion turned to what occurs when a provider fails to respond to the attestation form. A member asked whether failure to respond to the form is an automatic cause for disenrollment. There was consensus around the room that DHS will need to have multiple avenues for outreach prior to taking action. Members commented that there may be providers who simply stop prescribing opioids because they recognize that they

are unable to develop policies and processes to safely monitor patients receiving opioids. Members voiced concerns about patient abandonment among this provider population, especially in smaller communities, as well as providers referring all chronic pain patients to clinics who provide opioid management. There is concern that these clinics are not able to absorb the patient population, and that these clinics provide integrated care. Members commented on the success of the ECHO programs—especially in rural communities—at preventing patient abandonment. For some providers, the resources provided are empowering them to be more proactive with their pain patient population.

Quality Improvement Activities

Rinn reviewed a number of quality improvement programs and resources developed by state and national organizations. She briefly addressed the Minnesota Hospital Association's current work to develop OPIP quality improvement resources. She then introduced Audrey Hansen from ICSI, and asked Audrey to provide an overview of the MN Collaborative's work on post-operative opioid prescribing. A copy of the MN Collaborative Call to Action was disseminated prior to the meeting. Hansen provided an overview of the work, and explained that surgical departments within member organizations selected specific procedures to analyze. In general, the surgical departments who are engaged in the project found they could reduce post-operative opioid prescribing by 40%. Participating health systems are in various stages of the process, but in general, prescribing is headed in the right direction and there is a lot of provider and patient education occurring.

A member asked whether there is comparison data from international sources. Hansen responded that most of the existing data is from very small studies. There is not a good comparison at this time. Discussion turned to ICSI's analysis of individuals receiving over 700 MME post-operatively. Hansen shared that ICSI asked systems to track the first prescription through 45 days. Discussion then turned to role of patient education in reducing dosage. Hansen shared that none of the organizations in the Collaborative have developed standardized patient education, but there is a definite need within the community. Employers are eager for standard education materials about pain, and there is a significant need for the state to assist with this education. Members discussed whether there are specific items that the education should address, and whether there are items that really make a difference for the provider and patient when managing pain.

Rinn reviewed the existing resources for quality improvement from the CDC and the AHRQ-funded Six Building Blocks project. The work group briefly reviewed some of the process measures provided by the CDC. These process measures were developed for implementation in electronic health records, and may be a useful resource for providers and systems engaged in the quality improvement process. A brief discussion ensued about the measures, and members voiced concern about promoting any measures that use days' supply as the measure of exposure. The consensus in the room was that MME remains the preferred metric, but members acknowledged that education about MME remains an ongoing process. Schiff clarified that the purpose of sharing measures as a resource is not to promote any specific measure. The state wants to know that they are using standard measures, and that there is a process in place to track improvement within their system.

The meeting adjourned early.