A week before Christmas, William Dicks, M.D., a family physician at the Sanford clinic in Bemidji, made the four-hour trek to Minneapolis to attend a two-hour task force meeting. It’s a long way to drive during a hectic time of year, and his doing so illustrates the concern he and other MMA members feel about the topic of prescription opioid addiction, abuse and diversion.

Dicks is just one of 17 physicians who have volunteered to sit on the MMA’s Prescription Opioid Management Advisory Task Force. Each physician, resident and student serving on the task force likely has a different reason for taking part, but they all share a similar goal — stemming the tide of prescription opioid addiction, abuse and diversion.

Statistics show that prescription drug abuse is the fastest-growing drug problem in the United States. The Centers for Disease Control and Prevention has found that approximately three out of four prescription drug overdoses are caused by opioids such as hydrocodone, oxycodone, fentanyl, methadone and codeine.

Furthermore, opioids play a role in 15,000 deaths annually and account for more than 340,000 emergency department visits each year.

Here in Minnesota, one in five admissions (20.2 percent) to addiction treatment programs in the Twin Cities metro area during 2011 was for heroin or other opioids. This is compared with 8.7 percent of admissions in 2005. Oftentimes, the drugs causing addictions and overdoses are misused meds prescribed by physicians just doing their jobs.

“More and more people are becoming addicted to these medications that have been prescribed by physicians, and they will continue to need higher and higher doses as their bodies become physiologically tolerant of the effects,” says task force member Drew Zinkel, M.D., an emergency medicine physician at Regions Hospital in St. Paul. “This has become a major public health epidemic not only in our community but in communities all across the United States.”

A desire to address prescription opioid abuse motivates task force members.

**BY DAN HAUSER**

In numerous settings, the issue of prescription opioid addiction, abuse and diversion has become an urgent topic. Given the role of physicians in prescribing opioids, the MMA knew it needed to get involved. The Board of Trustees authorized the creation of a task force to launch its analysis of the issue. The roster filled up quickly. In fact, MMA staff had to set limits on the number of members in order to ensure the group didn’t become unwieldy because of its sheer size. The MMA wanted to include representatives from a number of key specialties: addiction/substance abuse, anesthesiology, emergency medicine, pain medicine, physical medicine and rehabilitation, family medicine, hospice and palliative care, internal medicine, occupational medicine and oncology.

As a pain medicine specialist, Alfred Anderson, M.D., was an obvious choice to include on the task force. After all, he deals with chronic pain sufferers daily at Medical Pain Management, Ltd. in St. Louis Park. His desire to take part, however, is predicated less on his concern about pre-
vent ing abuse and more on preventing a “chilling effect,” in which physicians prescribe less in order to curtail misuse.

Anderson can recite many stories that illustrate how prescribing opioids is supposed to work. For example, one of his patients is a 40-something woman who suffered from lower back pain for several years. Her pain became so bad that it prevented her from participating in recreational activities with her family. She underwent two lumbar surgeries, yet the pain persisted, limiting her ability to function. Anderson started her on a relatively low dose of hydromorphone, which was gradually titrated up until she had improved function. With the addition of a time-release form of the medication, she substantially increased her ability to exercise and take part in normal day-to-day activities. Last year, she took her children to Disney World, and only took a break when they needed to rest.

“She has been absolutely delighted with her new life, as has her family,” Anderson says. “She is now able to function daily at a nearly normal level of activity.”

Anderson is quick to add that his patients are concerned about the publicity regarding prescription medication abuse, and how it is going to affect their future care. “These medications have helped patients get back to work, increase their function with their family, and participate in recreational activities,” he says.

The good and the bad

Few would argue that prescription opioids are useful for patients striving to manage their pain. However, when the meds are abused or misused, it creates issues for other physicians.

“From my perspective, as an emergency physician, I have seen the negative impact that abuse and misuse of opioids has had on our community,” Zinkel says. “We see countless patients who have overdosed on these medications, both intentionally and unintentionally, and the impact and cost it has on the system of medical care as well as the health of the community.

“I would like to see a decrease in the negative impact opioid medications are having on our patients and our community,” Zinkel says. He would also like to see physicians prescribe fewer opioid medications and increase their use of non-narcotic therapies to treat pain, as well as increase use of Minnesota’s Prescription Monitoring Program.

Anderson points out non-narcotic therapies don’t always do the trick. “Most all of my patients have been through extensive previous treatment including conservative treatment programs, multiple spine surgeries and spinal implant procedures,” he says. Yet, he recognizes that opioids are not the sole answer for treating their pain. In order to enhance their ability to function, chronic pain patients should engage in a treatment program that includes increased activity, dietary changes when necessary, psychological counseling and treatment, and encouragement and support as well as prescription opioids.

“It is a physician’s true nature to want to provide relief to their patients, as this is what patients seek,” Zinkel says. “However, if physicians don’t understand the risks and dangers of prescribing opioids to patients and explain this to the patient, we will continue to see the problem of opioid abuse on the rise.”

It’s clear by talking to just a few physicians that a lot of passion surrounds this issue. Task force members certainly have their hands full.

As this issue went to press, the group planned to begin its work on a detailed analysis of the Prescription Monitoring Program. The task force is expected to meet until late 2013. We will continue to keep you updated on its progress.

EDITOR’S NOTE: Have an opinion or story about how the prescription opioid issue affects your practice? What are you doing in your practices regarding prescription opioids? Let us know. Send an email to Juliana Milhofer at jmilhofer@mnmed.org.
Health care task force finalizes its Roadmap

After 65 public meetings in locales ranging from Rochester to Duluth, the Governor’s Health Care Reform Task Force met for the last time and completed its “Roadmap to a Healthier Minnesota” in mid-December.

The Roadmap is a mix of recommendations that are likely to become health care-oriented legislation. Highlights include:

• bolstering the state’s primary care workforce
• increasing support for health profession education
• increasing the number of health professionals in underserved areas of the state
• determining a private-public process for setting performance targets including goals for health care access, cost containment, quality, patient experience and population health
• expanding Medicaid to individuals with incomes up to 138 percent of the federal poverty level
• implementing a Minnesota-based health insurance exchange that uses a public-private governance structure.

Although the MMA was generally supportive of the recommendations, it asked for revisions to three “strategy elements” in the Roadmap. Ultimately, the task force did not agree to the revisions.

In a letter signed by MMA President Dan Maddox, M.D., the MMA spoke out against the task force’s recommendation to “explore and remove regulatory barriers to the advancement of the nursing workforce,” which involves enacting the Advanced Practice Registered Nursing (APRN) Model Act and Rules that would provide all APRNs with independent practice and prescribing privileges.

Noting that the Roadmap recommendations involve improving care coordination and integration of care, the MMA felt that “implementation of the APRN Model Act would run counter to that goal and would actually erode collaborative practice that is currently part of Minnesota’s APRN law.”

The MMA urged the task force to reject the idea of pursuing independent practice for all APRNs and noted that under current law, not all APRNs deliver primary care services. The MMA supports regulatory changes to ensure more effective and efficient inclusion of APRNs in the delivery of care, but not if such changes will allow them to practice independently without a collaborative agreement with a physician.

In another strategy element, the “Roadmap” aims to “prepare for anticipated increased demand on safety net provider services by increasing reimbursement to safety net providers for primary care, mental health, substance abuse and community-based services provided to Minnesota Health Care Program recipients.” Concerned that this recommendation is too narrow, the MMA urged the task force “to expand the recommendation to increase reimbursement to all providers serving Minnesota Health Care Program recipients.”

The MMA specifically noted that as the individual mandate and other insurance coverage options take effect in 2014 as a result of federal health care reform, the increased demand on the health care system, particularly primary care physicians and other providers, could be significant. Yet, the state has failed to adequately invest in physician reimbursement for caring for Medicaid patients. There has been only one across-the-board increase in fee-for-service rates in 20 years; that occurred in 2000.

In a third strategy element, the Roadmap recommends use of a “public-practice process to set performance targets including goals for health care cost containment, health care quality, patient experience and population health.” The MMA acknowledged the potential value of defining performance targets, but questions about the scope of this recommendation remain. For example: the composition of the public-private partnership, the need to avoid duplication of current measurement efforts, and the feasibility and value of imposing consequences if the targets are not met.

“The task force did a nice job of gathering input from a variety of Minnesotans,” says Janet Silversmith, MMA director of health policy. “We certainly appreciate all of the physicians who attended meetings and voiced their opinions.”

MMA members Doug Wood, M.D., and Therese Zink, M.D., served on the task force.

Few people in Minnesota’s health care industry would argue against the need for more primary care physicians, particularly in rural parts of the state. We are currently facing a serious physician shortage; there are too many patients and not enough doctors. Factor in the influx of newly insured patients that will come as a result of the rollout of the Affordable Care Act and we could have an even more serious shortage on our hands.

So how do we address it? One solution that has been proposed (and may result in changes to state law) is to grant advanced practice registered nurses (APRNs) more independence. The theory goes that if APRNs are afforded more autonomy for prescribing medication and performing other duties, it will make health care more accessible in areas where the physician shortage is most acute.

But can we allow this and still maintain our high standards of patient care? We don’t think so.

APRNs have an extremely important role in the overall delivery of care. This is especially true as the industry moves toward patient-centered, team-based care in health care homes. But they are only one piece of the puzzle. Physicians, nurses, APRNs, physician assistants, dieticians, care coordinators and pharmacists all play a role on these teams. The key to making this approach to care delivery work is the emphasis on collaboration, with each player performing the functions they have been trained to do.

Some may see this as a turf war, but it really is a patient safety issue as I told the Star Tribune in an article on this topic in December. APRNs do an excellent job but they do not have the same training and experience as physicians and should not be treated as if they did.

Compounding the situation is the fact that we face a growing problem of prescription opioid addiction, abuse and diversion in our state and across the country. Allowing for more independent prescribers such as APRNs, who have less training than physicians, could potentially add to the problem.

Current Minnesota law requires APRNs to practice in a collaborative role under “a mutually agreed-upon plan” with one or more physicians or surgeons. We support changes that ensure that APRNs are used in the most effective way. But we also strongly believe that the care of the patient should be our No. 1 concern, and we must ensure that they are receiving the right care from the practitioner best trained to provide it.

This is a sound medical practice that we should continue to follow. It speaks to professionalism in medicine, and it’s best for the patient’s welfare.
News briefs

**Group to study Minnesota primary care physician workforce growth**

At its January meeting, the MMA’s Board of Trustees approved the formation of a task force that will study how to increase Minnesota’s primary care physician workforce.

Based on feedback from the Board, the task force will likely begin its work by defining “primary care” and whether the term encompasses more than family medicine, pediatrics and internal medicine.

“Another important task this group will address is planning and convening a summit to identify and share strategies on this issue,” says Juliana Milhofer, MMA policy analyst. The summit will likely take place during the second quarter of 2013.

In addition, the task force will work to:

- Understand the various drivers affecting the capacity and future supply of Minnesota's primary care physician workforce
- Identify strategies for increasing the workforce in the state
- Determine roles for the MMA, as well as other potential stakeholders, in advancing specific strategies to increase the workforce
- Recognize the relationship between workforce expansion efforts and other nonphysician primary care workforce initiatives and
- Partner with others, as needed, to increase the visibility and importance of the issue of workforce capacity among policymakers and the public.

The task force, which will begin its work during the first quarter of this year, is expected to meet six times over the next 12 to 15 months. It will include 15 to 20 physicians from both academia and the community.

(continued on next page)

**MMA in action**

In January, Dan Maddox, M.D., MMA president; Robert Meiches, M.D., MMA CEO; and Terry Ruane, MMA director of membership, marketing and communications, attended the Zumbro Valley Medical Society’s annual meeting in Rochester.

Maddox attended the Twin Cities Medical Society’s annual meeting in Minneapolis in January.

Ruane attended the Stearns Benton Medical Society board of directors meeting in December.

Jaime Olson, MMA manager of continuing education, and Robert Moravec, M.D., MMA speaker of the House of Delegates, attended the Accreditation Council for Continuing Medical Education State Medical Society conference in Chicago in mid-December.

The following MMA staff members met with Minnesota Hospital Association staff in mid-December to discuss the 2013 legislative session and health care reform: Meiches; Janet Silversmith, director of health policy; Dave Renner, director of state and federal legislation; Eric Dick, manager of state legislative affairs; Juliana Milhofer, policy analyst; and Teresa Knoderle, policy counsel. They also met with representatives from the Minnesota Department of Human Services in early January to discuss the 2013 session, health care reform implementation, and the 2013-2014 Medicare rate increases for primary care.

In January, George Lohmer, MMA CFO; Ruane, Meiches, Silversmith and Renner met with Minnesota Medical Group Management Association staff regarding partnership opportunities and the 2013 legislative session.

In late December and early January, Renner and Dick met with the following health care committee chairs: Sen. Tony Lourey (Finance - Health and Human Services Division), Sen. Kathy Sheran (HHS Policy), Rep. Tom Huntley (HHS Finance) and Rep. Tina Liebling (HHS Policy).

Renner also attended the AMA’s State Legislative Strategy Conference, an annual meeting of state and specialty medical society representatives in January. While there, he participated in the executive committee meeting of the AMA’s Advocacy Resource Center, on which he serves as vice-chair. This group of 15 state medical society staff members helps direct the AMA’s state legislative work.

In early January, the MMA Resident-Fellow Section hosted a “Taste of Thailand” at the Cooks of Crocus Hill in St. Paul.
Minnesota’s exchange efforts continue moving forward

Minnesota’s efforts to establish a state-run health insurance exchange reached another milestone in mid-December when the U.S. Department of Health and Human Services granted conditional approval of its plan. Then on the second full day of the 2013 legislative session, a bipartisan team of state lawmakers introduced a bill that would create a Minnesota-based exchange.

The exchange is a top priority for the MMA’s legislative team. “Our main goal is to ensure that governance of the exchange is a shared public-private model with broad representation, including the voice of practicing physicians and patients,” says Dave Renner, MMA director of state and federal legislation.

The MMA also wants the exchange to be funded either through the state’s general fund or by those entities that most directly benefit from it.

The exchange is scheduled to be open to individuals and small employers by October.

MMA supports Health Department’s cardiovascular care work

In late December, the MMA sent a letter of support to the Minnesota Department of Health recognizing its efforts to develop and implement statewide systems to optimize care for time-critical cardiovascular conditions.

“This work will assist Minnesota in developing effective policies and protocols for the diagnosis and treatment of patients with heart disease and stroke, and it will ensure that all Minnesotans have access to high-quality care,” wrote MMA President Dan Maddox, M.D., to Health Commissioner Edward Ehlinger, M.D.

Although Minnesota’s overall death rates due to heart disease and stroke are much lower than those elsewhere in the country, these conditions hit some communities harder than others. For example, coronary heart disease death rates are higher among American Indians, compared with other racial groups. In regards to deaths attributable to stroke, the rates are higher among American Indians, African Americans and Asians, compared with whites in Minnesota.

The letter is in response to a resolution submitted by the Twin Cities Medical Society and passed by the House of Delegates at the 2012 MMA Annual Meeting.

New physician joins MEDPAC board

Lisa Erickson, M.D., an OB-GYN at the Center for Reproductive Medicine in Minneapolis, has joined the board of directors for MEDPAC, the MMA’s political action committee.

Erickson is active in both the MMA and the Minnesota Chapter of ACOG, the American College of Obstetricians and Gynecologists.

“The board is happy to welcome Dr. Erickson to its fold,” says Will Nicholson, M.D., MEDPAC secretary-treasurer. “She brings great energy, passion and experience with legislative advocacy on behalf of medicine.”

Several openings remain on the MEDPAC board. Interested MMA members should contact Eric Dick, MMA manager of state legislative affairs, for more information (edick@mnmed.org). You can also learn more about MEDPAC at www.mnmed.org/Advocacy/MEDPAC.

Insights article on “providers” leads to engaging discussion

An Insights entry denouncing the use of the word “providers” to describe physicians led to more than two dozen online and email responses in early December.

Apparently, the piece by Robert Meiches, M.D., MMA CEO, struck a chord.

“Addressing a physician as a ‘provider’ is demeaning and controlling, and I support any effort to roll back this practice,” responded one physician.

“The term ‘provider’ in my personal opinion was introduced (and pushed for acceptance and wide use) to degrade physicians and the noble aspect of their profession,” wrote another.

“It’s about time someone addressed this issue,” commented a third.

Launched in the fall of 2012, Insights is a quarterly email distributed to MMA members and penned by MMA leaders to take a stance on issues facing physicians. To read the latest entry, go to Insights beneath the “Publications” banner on the MMA website.

EDITOR’S NOTE: Keep track of news through MMA News Now, which is delivered to your email box free each Thursday. To subscribe, go to www.mnmed.org and look for “MMA News Now” under the “Publications” tab.

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