MINUTES

MMA PRESCRIPTION OPIOID MANAGEMENT ADVISORY TASK FORCE
Tuesday, September 13, 2016
6:00 – 8:00 P.M.
1300 Godward Street NE, Suite 2500
Minneapolis, MN 55413

Members Present
Beth Baker, MD, MPH, Chair
Alfred Anderson, MD
Paul Biewen, MD
Michele Cowling, MD
Mark Eggen, MD
Tom Flynn, MD
Christopher Johnson, MD
Charles Reznikoff, MD
David Schultz, MD
Pamela Shultz, MD
Keith Stelter, MD
Lindsey Thomas, MD
Joseph Westermeyer, MD, MPH, PhD

Members Absent
Elisabeth Bilden, MD
William Dicks, MD

Staff Present
Juliana Milhofer
Janet Silversmith (via conference call)

Guests Present
None

I. Call to Order & Introductions
The MMA Prescription Opioid Management Advisory Task Force was called to order at 6:00 pm by Beth Baker, MD, MPH, task force chair.

II. Review of Task Force Charge and Goals
Dr. Baker and Juliana Milhofer, MMA Policy Analyst and task force staff, welcomed the task force members to “Phase II” of the MMA Prescription Opioid Management Advisory Task Force.

Ms. Milhofer informed the task force that, per the direction of the MMA Board of Trustees, the MMA Public Health Committee was asked to assess what additional efforts, if any, the MMA should engage in to address prescription opioid addiction, abuse and diversion. At the April 13, 2016 meeting of the MMA Public Health Committee, committee members had the opportunity to
learn about MMA’s efforts regarding prescription opioid addiction, abuse and diversion, as well as related efforts in the community and nationwide. Chris Johnson, MD, MMA Board of Trustee member and member of the MMA Prescription Opioid Management Advisory Task Force, was a guest at the meeting and provided the committee members with some background on the issue as well. After the presentations, committee members engaged in an assessment of what other efforts the MMA should engage in.

Based on the committee’s input, draft recommendations were put together. Themes that arose included the need for a strong public health statement from the MMA, convening of stakeholders, reconvening of the MMA Prescription Opioid Management Advisory Task Force, public education, the need to examine opioid prescribing data to support benchmarking and improved prescribing practices, etc. The MMA Public Health Committee presented a list of their proposed recommendations to the MMA Board of Trustees at their July 18, 2016 meeting. The recommendations were subsequently approved, and the MMA Prescription Opioid Management Advisory Task Force was thus reconvened.

Ms. Milhofer noted that the task force was reconvened because the MMA recognized that additional strategies to improve physician management of opioid prescribing were needed. The task force is charged with developing recommendations for consideration by the MMA Board of Trustees on the following topics:

1. The potential circumstances for when mandatory use of the Minnesota Prescription Monitoring Program may be appropriate.
2. The potential circumstances for when required education/additional training with respect to opioid prescribing may be appropriate.
3. Strategies for expanding the number of buprenorphine providers.

The task force is also charged with reviewing the recommendations from the DHS Opioid Prescribing Work Group to help guide MMA response.

Ms. Milhofer informed the task force that over their next few meetings, they will be focusing on the first three pieces of the charge. In early 2017, they will convene again to discuss the fourth piece of the charge.

III. Minnesota Prescription Monitoring Program

Task force members took some time to address the first piece of the charge of the task force. The charge reads as follows: “The potential circumstances for when mandatory use of the Minnesota Prescription Monitoring Program may be appropriate.”

The task force members engaged in a thorough discussion of how best to approach the charge related to the Minnesota Prescription Monitoring Program (“MN PMP”). Some comments from the task force included the following:
One of the barriers to use of the MN PMP is its lack of interoperability with the electronic health record ("EHR"). Ease of use is a critical component currently lacking in the MN PMP.

A mandate for use is worrisome, given the barriers that exist in using the system. Also, a mandate is difficult as not every physician prescribes opioids.

The MN PMP is a useful tool, with some limitations.

Some physicians feel that a mandate may be used against them if the system interprets legitimate opioid prescribing for certain patient populations as "overprescribing."

Physicians should be able to prescribe using their clinical judgment.

Would there be an opportunity to ask for state funding for integration of the MN PMP and EHR’s?

What role can a standard of care, best practices, and/or guidelines play?

A mandate, however comprehensive, should be accompanied by assurances of the protection of physicians.

Need to ensure that all patients are treated civilly. Assumptions that patients are drug-seekers are becoming too common, and some patients are not being appropriately treated for their pain.

Need to ensure that any action (whether a guideline or a mandate) recognizes that there are patients for whom opioids may be appropriate, and for whom the MN PMP checks may not be warranted (e.g., hospice, palliative care, terminal cancer).

Some benefits of checking the MN PMP include the notion that a query of the system may assist in identifying a drug interaction that a physician didn’t anticipate.

Mandates for use of the MN PMP may pose a potential burden for both acute and chronic pain patients.

Prescription opioids don’t represent the only epidemic we face – tobacco use and alcohol use cited as examples of other epidemics.

Important to provide physicians with education on use of the MN PMP.

In discussing potential criteria for a MN PMP selective mandate, the task force members discussed criteria laid out by both the Centers for Disease Control and Prevention ("CDC") and the Institute for Clinical Systems Improvement ("ICSI"). Some criteria highlighted by the task force included the following:

- Initial prescription (it was noted that this could present a burden for certain specialties).
- Concerns with high risk patients.
- Periodic checks for continued use of prescription opioids.

It was also noted that another option would be to set a target date and target goal for use of the MN PMP. Since physicians are now required to use the MN PMP, we can set targets for use, and if physicians don’t meet those targets, we can revisit the issue of mandatory use at a later date.
Dr. Baker and Ms. Milhofer thanked the task force for the discussion and informed them that based on their input, they would be bringing draft language to their next meeting.

IV. **Training and Education on Opioid Prescribing**

Task force members took some time to address the second piece of the charge of the task force. The charge reads as follows: “The potential circumstances for when required education/additional training with respect to opioid prescribing may be appropriate.”

The task force members engaged in a thorough discussion of how best to approach the charge related to required training and education on opioid prescribing. Some comments from the task force included the following:

- One of the concerns related to mandating continuing medical education (“CME”) is that the field of pain management is evolving so fast, and the knowledge base isn’t ironed out like other areas. Physicians can’t assume that the tools that currently exist will be the tools that are needed a few years from now.
- The interstate medical licensure compact was noted, and how having physicians licensed in multiple states will make a CME mandate difficult.
- It will be important to lay out what education already exists in this area.
- Different specialties will need different training.
- Should we charge the medical schools to improve their curriculum as it relates to pain, opioid prescribing, and addiction?
- If we are to have a mandate for training and education, we should provide physicians with a menu of options, which are relevant to their practice, and evidence-based. We need to ensure that we have the appropriate expertise behind the training and education.
- Some states currently have mandatory CME in this area. Examples given were Maine, Massachusetts, and California.

Dr. Baker and Ms. Milhofer thanked the task force for the discussion and informed them that based on their input, they would be bringing draft language to their next meeting.

V. **New Business**

Dr. Baker and Ms. Milhofer thanked the task force for their input and for their dedication to addressing the addiction, abuse and diversion of prescription opioids. Task force members were informed that the next meeting would take place on October 13th.

VI. **Adjourn**

There being no additional business, the meeting was adjourned at 8:00 pm.