Illinois Opioid Crisis Response Advisory Council

Prescribing Practices Committee Meeting

November 2, 2017

MEETING MINUTES

Chair: Mike Nelson

Committee Members at the Meeting (in person and phone): Martin Clancy, Corey McGee, Sarah Pointer, Mila Tsagalis, Neeraj Chhabra, Adrienne Hersch, Nathan DeFoe, Garth Reynolds, Kathleen Burke, Lindsay Wagahoff, Ankur Dave, Jon Bloomfield, Susan Bence, Brian Zachariah, Mai Pho, Fran Langdon, Mike Wahl, Aaron Weiner, Elizabeth Salisbury-Afshar

DASA and AHP Representatives: Rafael Rivera, Sue Pickett

Task Force Update

Sue shared with the group that the Task Force has requested that the Committees finalize their recommendations by December. Recommendations need to be prioritized and ranked; rankings need to take into account each recommendation's costs and impact. Committees also need to consider current resources and what we have available now when prioritizing their recommendations. The Task Force will review recommendations at their January meeting and give feedback to the Council in February.

Discussion: Prioritizing Recommendations for Strategy #1 (Increase PMP use by providers.

Recommendation #1: Give delegates and non-traditional prescribers (RNs, PAs, CNPs, ME/Coroners) access to the PMP.

- Giving delegates access is currently in process – the PMP plans to have delegate access available by the end of the calendar. Sarah will send information on this process to the Committee.
    - Under current rules, each physician can have three designees. While this may work well for physicians in office-based clinics, it may not be feasible for physicians in large hospital systems, since they may be in different offices on different days; could they work with other doctors' designees who are providing care to patients? The PMP agrees with the Illinois Hospital Association (IHA) that, as currently written, the designee rule does not work for hospital systems, and changes need to be made. Additionally, changes may need to be made to expand authorized designees to include PAs and MEs/Coroners.
        - Sarah asked the Committee to send her suggestion for delegate wording (Sarah.Pointer@illinois.gov). She also will explore what other states have done in regard to PMP designee access.
    - Guidelines for designee access to the PMP, provider verification and confirmation of designee's activity, and checks and balances to ensure and monitor designee log ins also are needed.
    - In short, the Committee agreed that anyone (i.e., designee) who is caring for a patient should have access to the PMP so that he/she can bring information about the potential opioid misuse/abuse to the patient's primary provider (i.e., physician). Recognizing that this requires a legislative rule change, the Committee agreed that this recommendation is a lower priority.

Recommendation #2: Ideally, have full integration of the PMP into electronic medical records (EMRs), recognizing that it is difficult to mandate integration as not all systems

are completely electronic. Possibly provide the state integration module for free and target larger hospital systems first.

- EMR integration is one of the PMP's current main initiatives. The PMP's goal is to have 37 organizations signed up for integration by the end of the year. Seventeen have signed up so far; and the PMP is working with 10 targeted hospitals on EMR integration.
- IHA believe that PMP and EMR integration should be a top priority; integration fits with physicians' workflows without changing their workflows.
- Dedicated funding for the PMP is needed. Currently, the PMP is supported by federal funds with some General Revenue Funding (GRF). It was noted that much is asked of the PMP but not much funding is allocated to it for the staff time and other resources needed to address barriers and achieve recommended goals.
    - Greater funding allocation could potentially increase integration. For example, the PMP could release and RFP for technical assistance and implementation costs, and award those funds to hospitals based on how the hospital demonstrated their need and capability for implementing and supporting integration.
- The Committee agreed that PMP/EMR integration is the higher priority recommendation. The group recognizes that this is a potentially costly recommendation, given integration costs. Dedicated funding for the PMP, and prioritizing who is targeted first for integration (e.g., hospital systems in the Delta region, smaller stand-alone hospitals) should be added to this recommendation.

Discussion: Prioritizing Recommendations for Strategy #2: Reduce high-risk opioid prescribing through provider education and prescribing guidelines.

Recommendation #1: Identify the highest prescribers in the State (e.g., top 5%) and evaluate their practice (potentially excluding certain specialists such as pain management, oncology and addiction medicine).

- Is identifying the top 5% highest prescribers an attainable goal? The PMP peer review committee is working on this: identifying the highest prescribers via PMP data and sending the letter to them noting their high opioid prescription rates, how their prescribing practice compares with their peers, telling them about risk mitigation tools, etc.
- Taxonomy is a challenge. Practice and prescribing norms differ by specialty. We want to exclude certain specialties, such as oncology and pain management, that may be high prescribers simply due to their specialty.
    - Taxonomy information is not included in the PMP. This information could potentially be obtained through CS licensing.
    - Peer review panels could review and establish guidelines for each specialty to more accurately identify the highest prescribers.
    - While we recognize that certain specialties, such as pain management, may by high prescribers of opioids, it may still be valuable to identify and reach out to the top 5% highest pain management prescribers.

Recommendation #2: Provide targeted outreach and education to high prescribers.

- Letters to high prescribers are not enough; focused intervention efforts also are needed.
- Current clinical guidelines and education resources are embedded in the PMP website. Sarah asked that the group check the website and let her know if/what other resources should be added. The website, and links to other educational resources could be included in the letter that will be sent to high prescribers.
- High prescribers need to know the current clinical guidelines – they need education on the guidelines for their taxonomy, and how their high prescribing falls outside the norms of their

specialty. High prescribers who fall outside of the norms for their taxonomy should receive targeted outreach and education.
    - Taxonomy prescribing norms need to be identified – how to best do that? Elmhurst Hospital example: core recommendations for prescribing guidelines were written, then specialists from each section wrote guidelines and considerations for how they work with opioids for their respective specialty.
- Site visits may have a bigger impact, but are costlier.

Recommendation #3: Require training on opioid prescribing as part of controlled substance (CS) licensing; also require that prescribers be registered with the PMP as part of CS licensing.

- The Executive Order requires IDFPR to look at prescribing guidelines. IDFPR is considering the FSMB guidelines rather than CDC guidelines since FSMB guidelines are less prescriptive. IDFPR also is looking at CMEs and potentially requiring 150 hours for CS licensing.
- What education component should be required outside of IDFPR requirements?
    - While we want everyone to have some degree of training, we want to avoid a blanket mandate. Training needs to be relevant to prescribers' practices.
    - Education and guidelines on managing people who are prescribed opioids and benzodiazepines, as well as co-prescribing guidelines, should be considered.
- Summary for Strategy 2: Identify the highest prescribers, recognizing that taxonomy needs to be addressed. Targeted outreach and education should be directed that those who prescribe outside the norms of their taxonomy's clinical guidelines. The PMP letter is a good option; face-to-face education (site visits) are preferred but are costlier. Education outside of the what the IDFPR will require needs to be considered (Note: This is a topic that needs further discussion).

Discussion/preliminary recommendations for Strategy #8 (Increase the number of first responders and community members who have access to and are trained to administer naloxone)

- Naloxone should be co-prescribed for 50 MMEs (morphine milligram equivalent) or higher as well as for those who are prescribed benzodiazepines.
    - MME calculators should be integrated into EMRs. The CDC's MME calculator is incorporated into the PMP
- Naloxone should be prescribed for people who have an OUD and/or a history of opioid overdose.
- Pharmacists who are filling scripts that are 50 MMEs or higher should offer patients naloxone.
    - Patients who are taking 50 MMEs or higher could get education about naloxone both from their physician and their pharmacist.

Recommendation: Naloxone should be co-prescribed for: 1) patients prescribed 50 MMEs or higher; 2) those who are co-prescribed benzodiazepines; and 3) patients who have a history of opioid overdose.

Note: Prescribing Practices Committee meeting minutes are posted on the Illinois Opioid Crisis Response Advisory Council's website: http://www.dhs.state.il.us/page.aspx?item=97186