Opioid Prescribing Improvement Program

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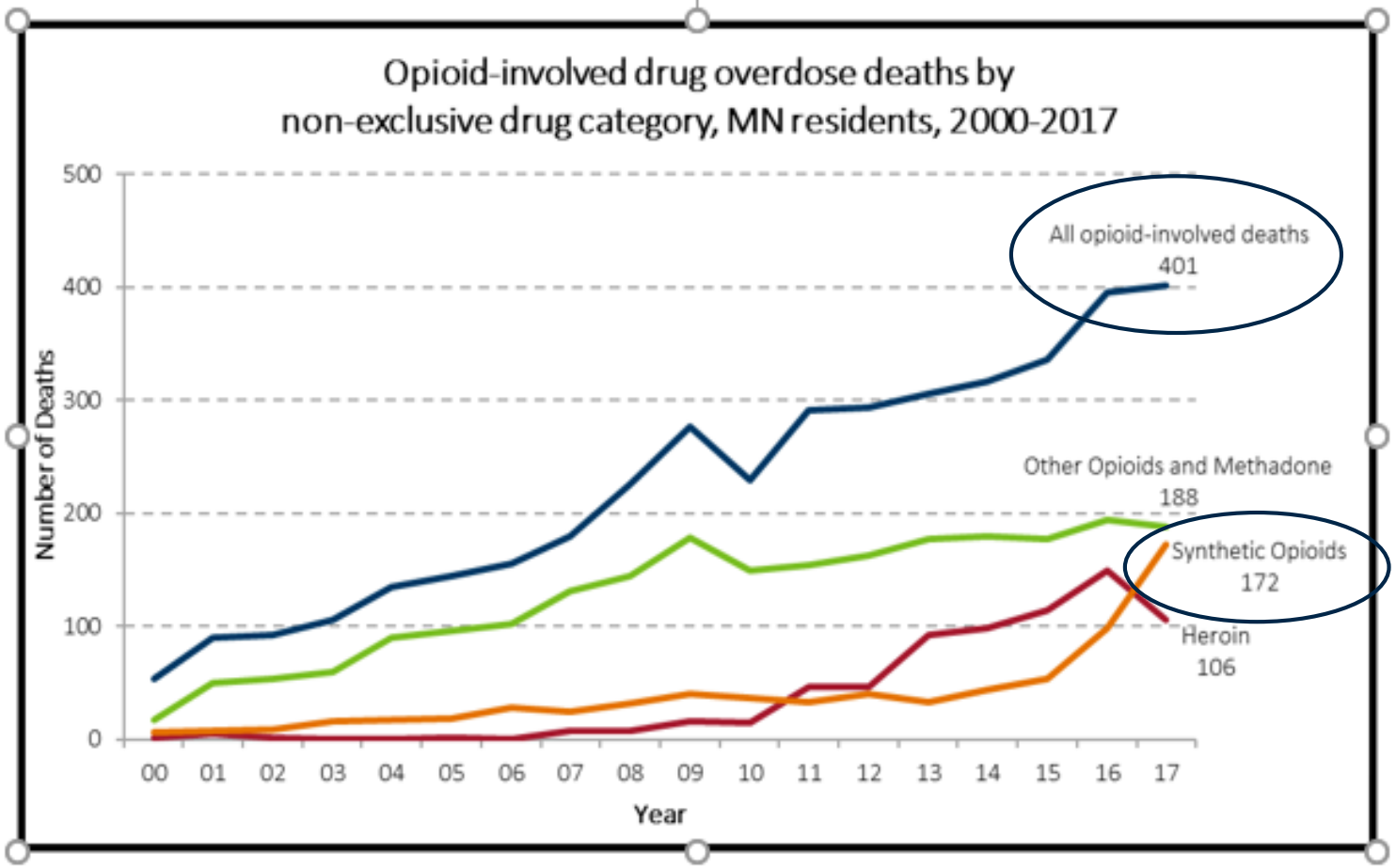
DEPARTMENT OF HUMAN SERVICES

Agenda

- Opioid Prescribing Improvement Program (OPIP) overview
- How the guidelines advance Minnesota's opioid efforts and relate to national opioid prescribing guidance
- Prescriber-level quality improvement program
- How pharmacists and health care organizations can support the statewide quality improvement process

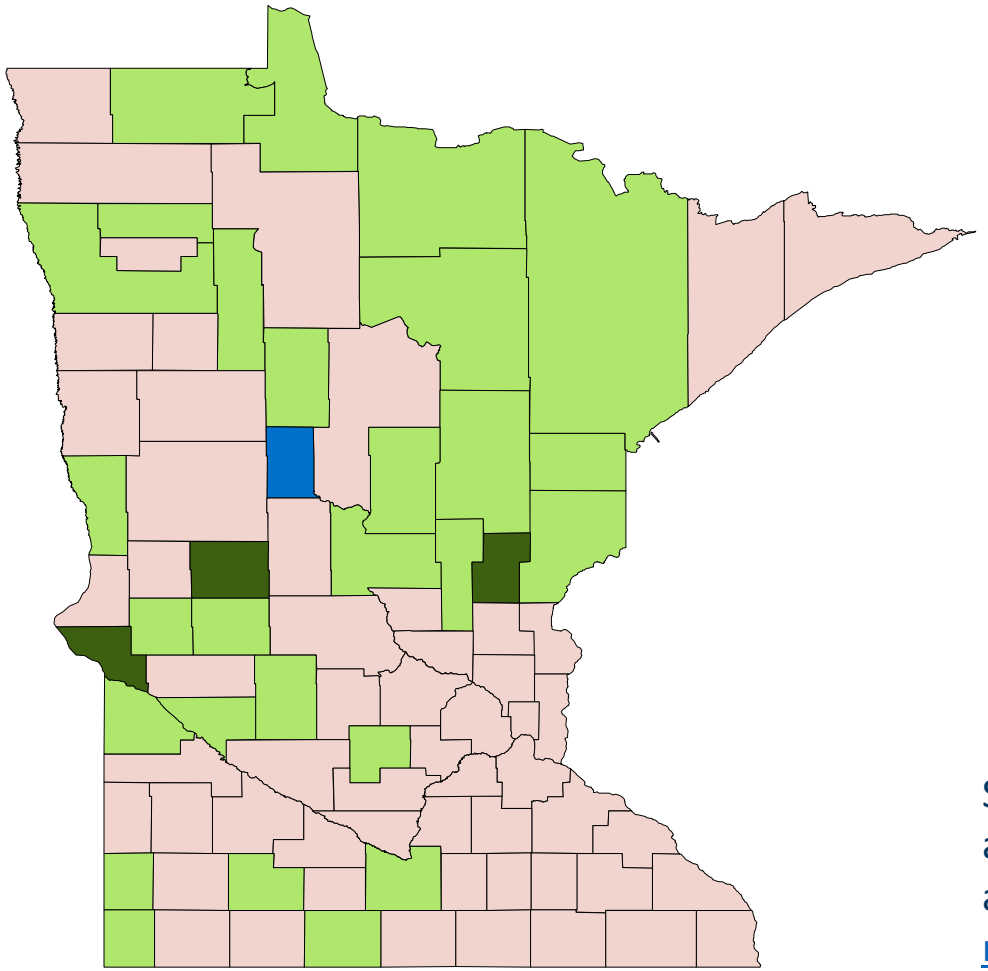
Drug overdose deaths: 2017; Minnesota
Minnesota Department of Health

Figure 2: Opioid-involved overdose deaths continue to rise in Minnesota, driven primarily by synthetic opioids



NOTE: Data are preliminary and likely to change when finalized.

U.S county prescribing rates, 2016; Minnesota Centers for Disease Control and Prevention



Prescribing Rate Map Key;
Rate per 100 persons

- < 57.2
- 57.2 – 82.3
- 82.4 – 112.5
- > 112.5

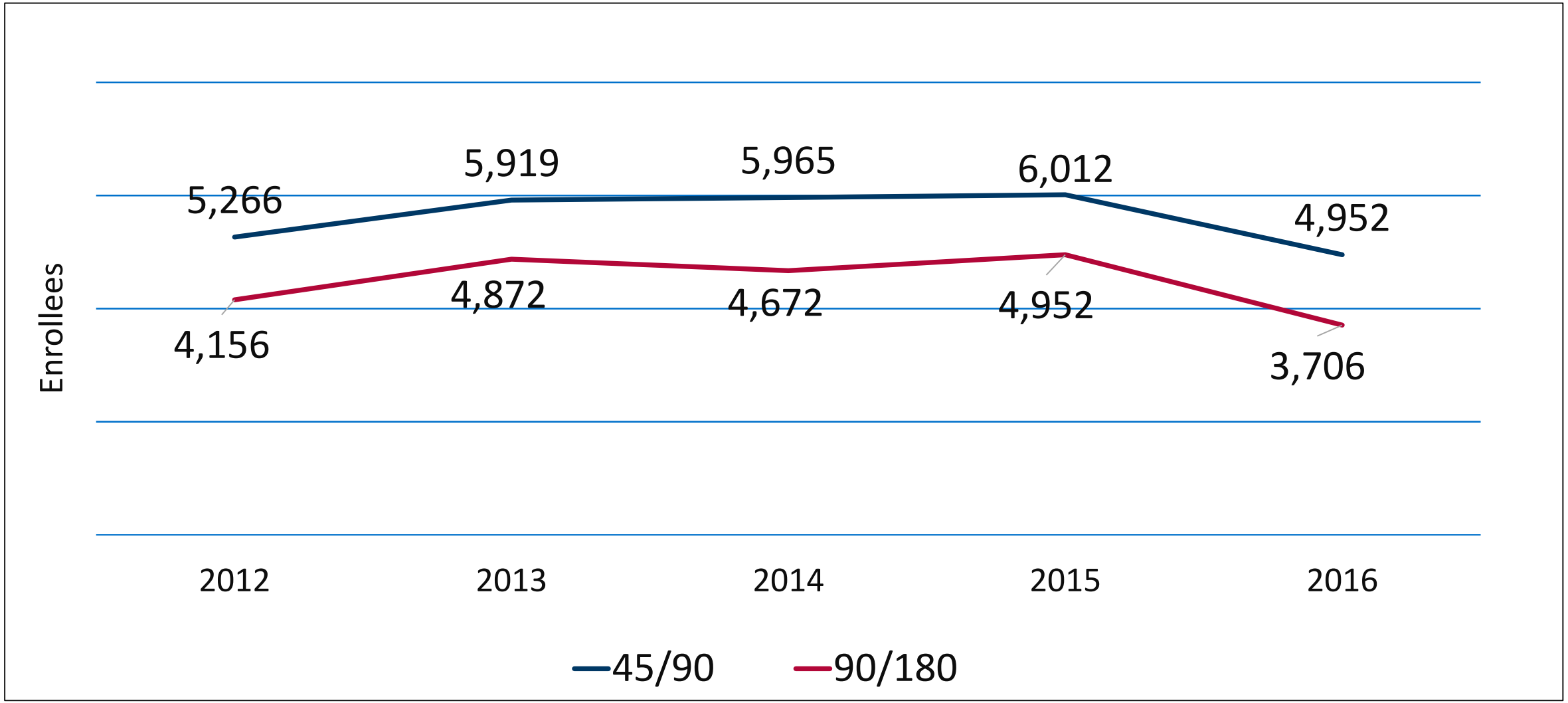
Source for all prescribing data: Centers for Disease Control and Prevention. U.S. Prescribing Rate Maps. 2016. Available at: https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html


Our stand is
only effective when
we take it together

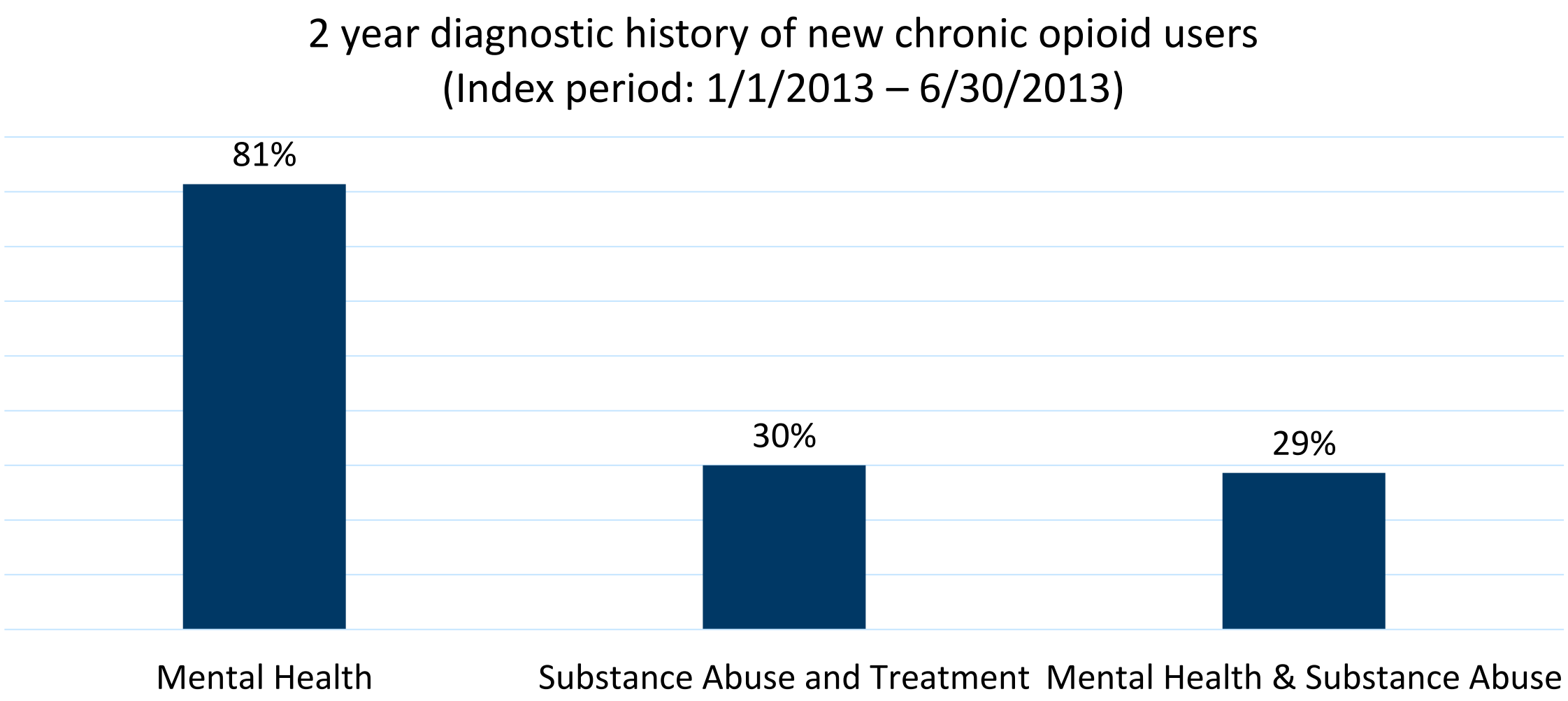
Where can MN stake a stand? Prevent unintentional or new chronic opioid use

- Developed a system-level performance measure to address the post-acute prescribing period
- Measure objectives
  - Evaluate prescription opioid utilization
  - Prevent the progression of acute or episodic opioid use to chronic use
  - Identify an early inflection point for quality improvement interventions
- New Chronic User measure
  - An enrollee who has not taken any opioids for 3 months (opioid naïve) before an index prescription, and then received more than a 45-day supply over the next 3 months

Number of New Chronic Users in the Minnesota Health Care Programs: 2012-2016



Prevalence of mental health conditions and history of substance use disorders among new chronic users



Opioid Prescribing Improvement Program Overview

- Common protocols
- Common measures
- Common messages
- Supportive policy levers

Opioid Prescribing Improvement Program (OPIP)

- Developed based on input from Health Services Advisory Council and with support from health care community
- Authorized during the 2015 legislative session
- Does NOT apply to hospice or cancer-caused pain
- Expert, community advisory body convened to develop program components
  - Opioid Prescribing Work Group

OPWG charged with recommending the following:

- Common opioid prescribing protocols
- Sentinel measures for each prescribing period
- Criteria for mandatory quality improvement among MHCP-enrolled providers
- Criteria for terminating providers from MHCP
- Educational messages for prescribers to give to patients

Minnesota Opioid Prescribing Guidelines; Key Principles

1. Prescribe the **lowest effective dose and duration** of opioid analgesia when indicated for acute pain. Clinicians should **reduce variation** in opioid prescribing for acute pain.

2. The post-acute pain period (up to 45 days following an acute event) is the critical timeframe to **halt the progression to chronic opioid use**. Clinicians should **increase assessment** of the biopsychosocial factors associated with opioid-related harm and chronic use during this period.

Minnesota Opioid Prescribing Guidelines; Key Principles

3. The evidence to support chronic opioid analgesic therapy for chronic pain is insufficient at this time, but the evidence of harm is clear. Providers should **avoid initiating chronic opioid therapy** for new chronic pain patients, and **carefully manage** those who remain on medication.

Clinical recommendations: Patient safety

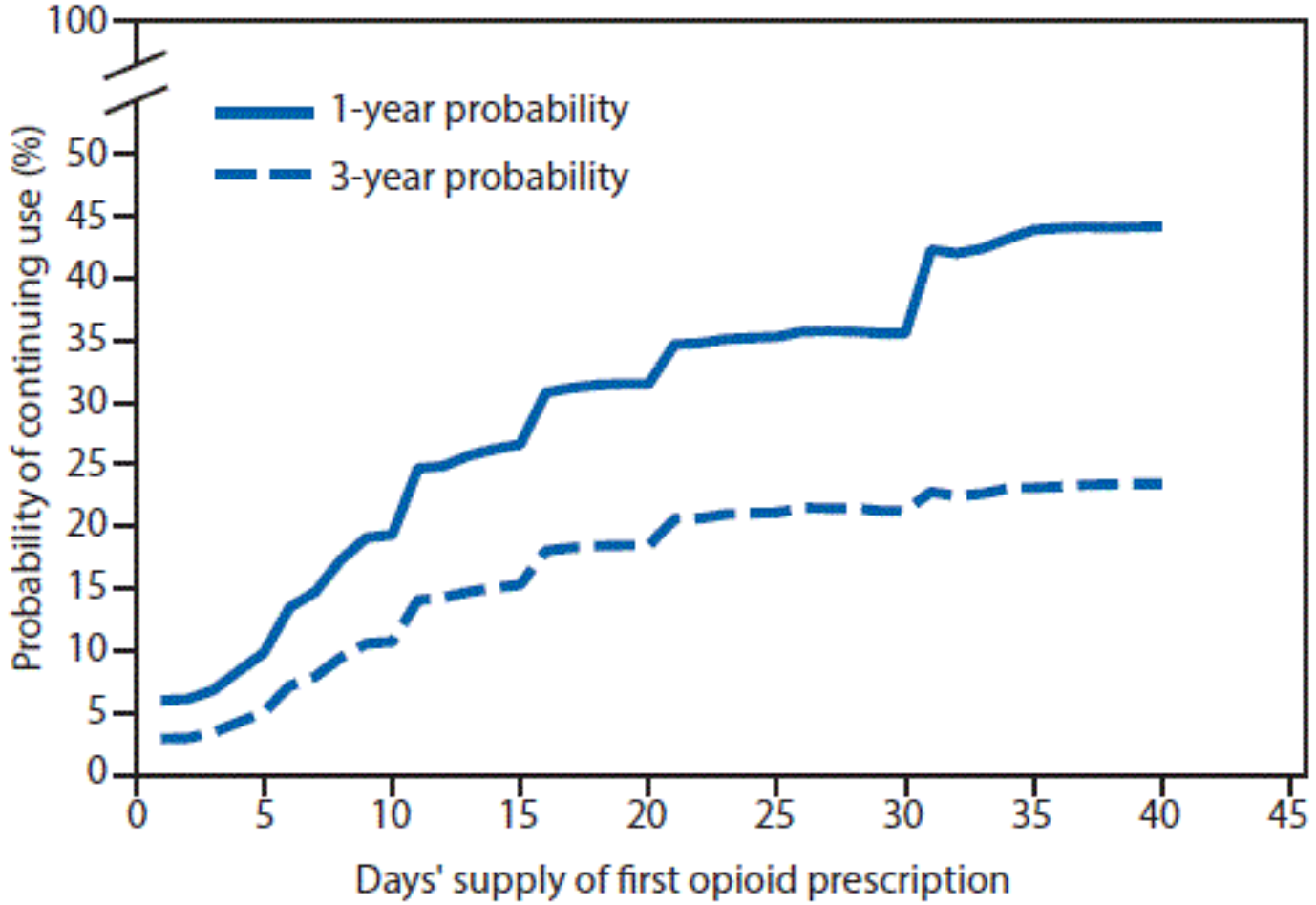
- Query the Prescription Drug Monitoring Program (PMP) every time opioid therapy is prescribed.
- Avoid concomitant opioid and benzodiazepine or other sedative-hypnotic use.
- Provide patient education on an ongoing basis that addresses:
  - Risks and benefits associated with opioid use
  - Self-management of painful conditions
  - Safe use, safe storage and disposal
- Consider co-prescribing naloxone to patients at elevated risk for overdose.

Clinical recommendations: Acute pain interval

- Avoid prescribing more than 100 morphine milligram equivalents (MME) of low-dose, short-acting opioids.
- Limit the initial acute prescription following extensive surgical procedures and traumatic injury to up to 200 MME, unless circumstances clearly warrant additional opioid therapy.
  - Certain surgical procedures may require additional pain management
  - Link to ICSI Collaborative Community Standards for Maximum MME Short-Acting Opioid Initial Post Surgical Prescribing Recommendations (tiered dose limits based on acuity)

Probability of continued opioids depending on initial total number of days supply

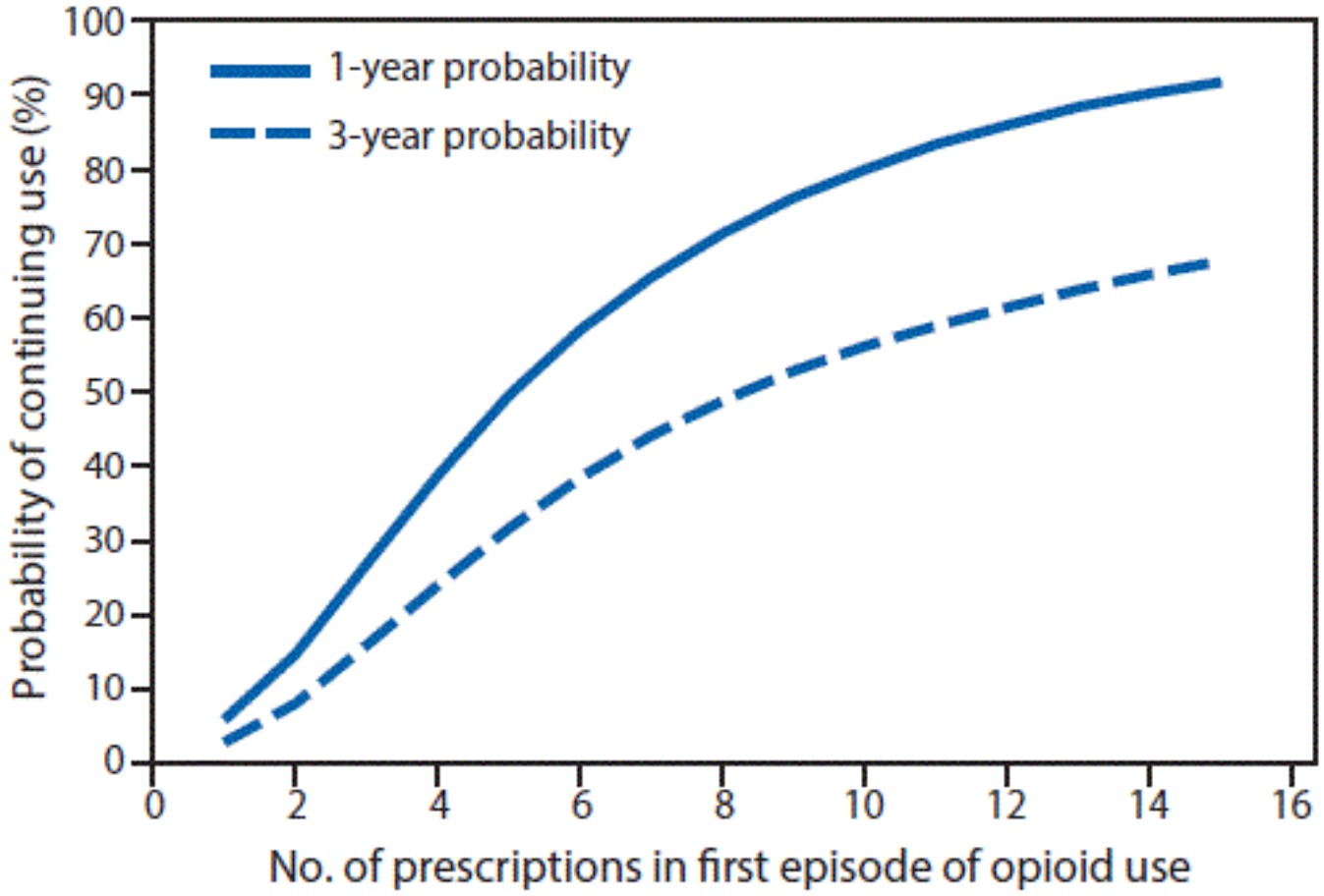
FIGURE 1. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of days' supply* of the first opioid prescription — United States, 2006–2015



Source: Shah A, Hayes CJ, Martin BC. Characteristics of initial opioid prescription episodes and likelihood of long-term opioid use – United States, 2006-2015. MMWR Morb Mortal Wkly Rep 2017;66(1):265-269. Available at: https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm

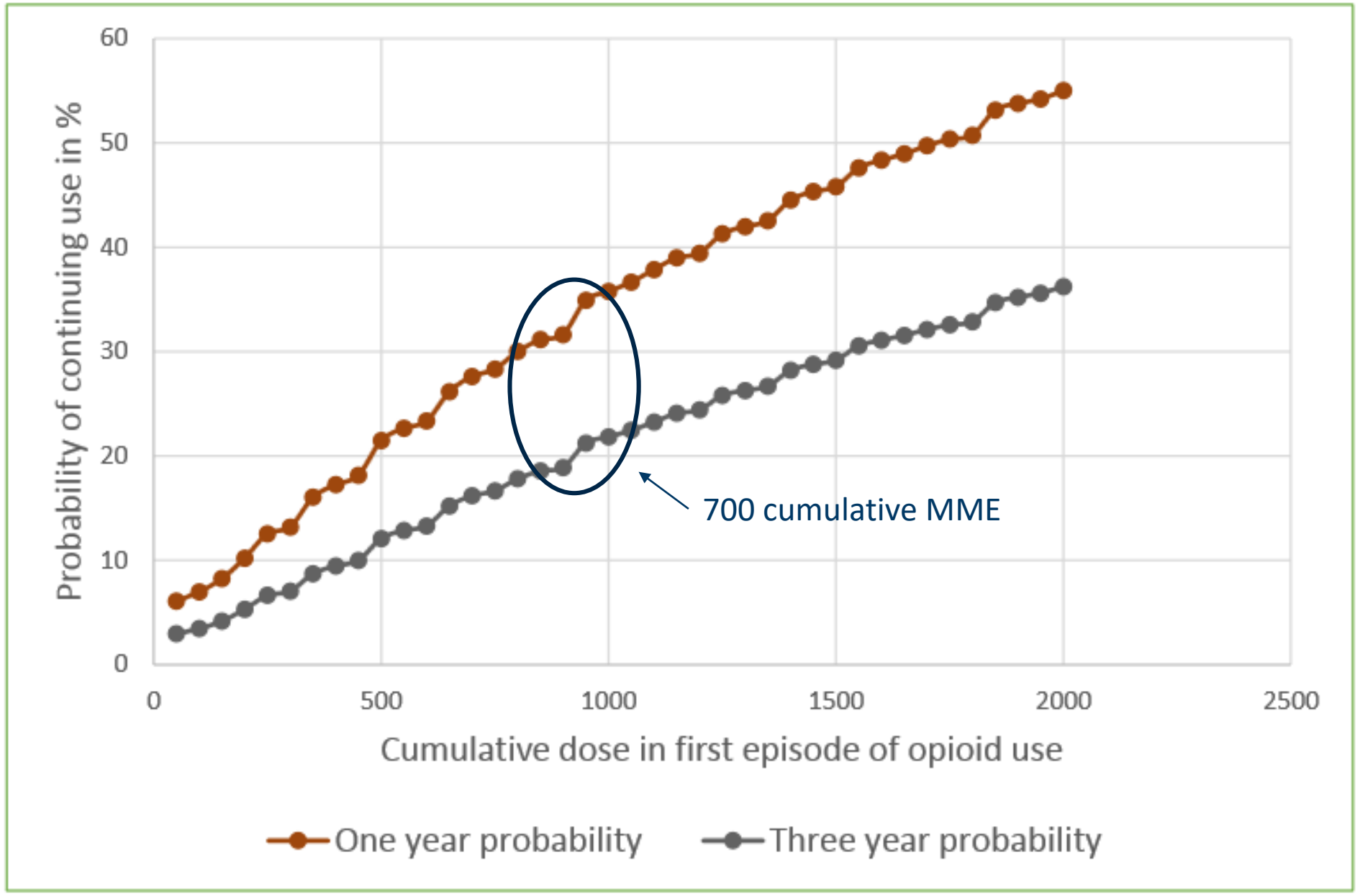
Probability of continued opioids depending on initial total number of scripts

FIGURE 2. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of prescriptions* in the first episode of opioid use — United States, 2006–2015



Source: Shah, 2017. Available at: https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm

Probability of continued opioid use depending on initial total dose



Source, Shah, 2017. Available at: https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm?s_cid=mm6610a1_w https://stacks.cdc.gov/view/cdc/44552

Clinical recommendations: Post-acute pain interval

- **Avoid prescribing more than 700 cumulative MME during the post-acute pain interval.**
- Prescribe opioids in multiples of 7 days, with no more than 200 MME per 7 day period. Prescribing should be consistent with expected tissue healing. Plan for expected tapering early in this treatment.
- Assess and document risk factors for opioid-related harm and chronic use during the post-acute pain phase.
  - Depression, anxiety, substance abuse, fear avoidance and pain catastrophizing

Clinical recommendations: Chronic pain interval

- Prescribe opioids at the lowest dose, with no more than 50 MME/day. Avoid increasing daily dosage to ≥ 90 MME/day.
- Face to face visits with the prescribing provider should occur at least every 3 months.
- Implement risk mitigation strategies when initiating chronic opioid analgesic therapy, and continue through the duration of therapy.
- Address tapering and discontinuing opioid therapy in advance of initiating therapy, and with every dose increase. Discuss with the patient tapering to a reduced dose or to discontinuation at least every 3 months.

Clinical recommendations: Taper or discontinue opioid therapy

- Address taper or discontinuation in advance of initiating chronic opioid therapy and at every dose increase.
- Offer to taper or discontinue therapy at least every three months.
- Taper opioid therapy to a reduced dose or to discontinuation when the risks outweigh the benefits.
  - Tapering high-risk patients to 50 MME/day is a reasonable initial goal.
- Offer non-opioid and non-pharmacologic therapies to treat pain and withdrawal symptoms during the taper.

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OPIP Sentinel Measures and Prescribing Data

Overview of opioid prescribing data; Minnesota Health Care Program enrollees, 2017

- 572,955 total opioid prescriptions
  - 133,568 index opioid prescriptions
  - 268,570 opioid prescriptions for enrollees receiving greater than 60 continuous days (chronic opioid analgesic therapy)
  - 179,817 other
- 1.2 million member years (approximately 1.2 million enrollees)
- The total number of opioid prescriptions **declined 17%** from 2016 to 2017

Measure terms

Index opioid prescription	The first opioid prescription in the measurement period after at least 90 days of opioid naiveté
Opioid naïve user	A patient prescribed an opioid medication in the measurement year who does not have an active opioid prescription in the 90 day period prior to the measurement year index prescription
Morphine milligram equivalence (MME)	The morphine equivalence of a specific opioid dose and formulation. The morphine equivalence is calculated using standard conversion ratios.
Chronic opioid analgesic therapy (COAT)	A ≥ 60 consecutive days supply of opioids from any number of prescriptions. A ≤ 3 day gap is permissible between prescriptions
High-dose COAT	A ≥ 60 consecutive days supply of opioids and the daily dose ≥ 90 MME.
Elevated-dose COAT	A ≥ 60 consecutive days supply of opioids and the daily dose ≥ 50 MME.

Index opioid prescription measures

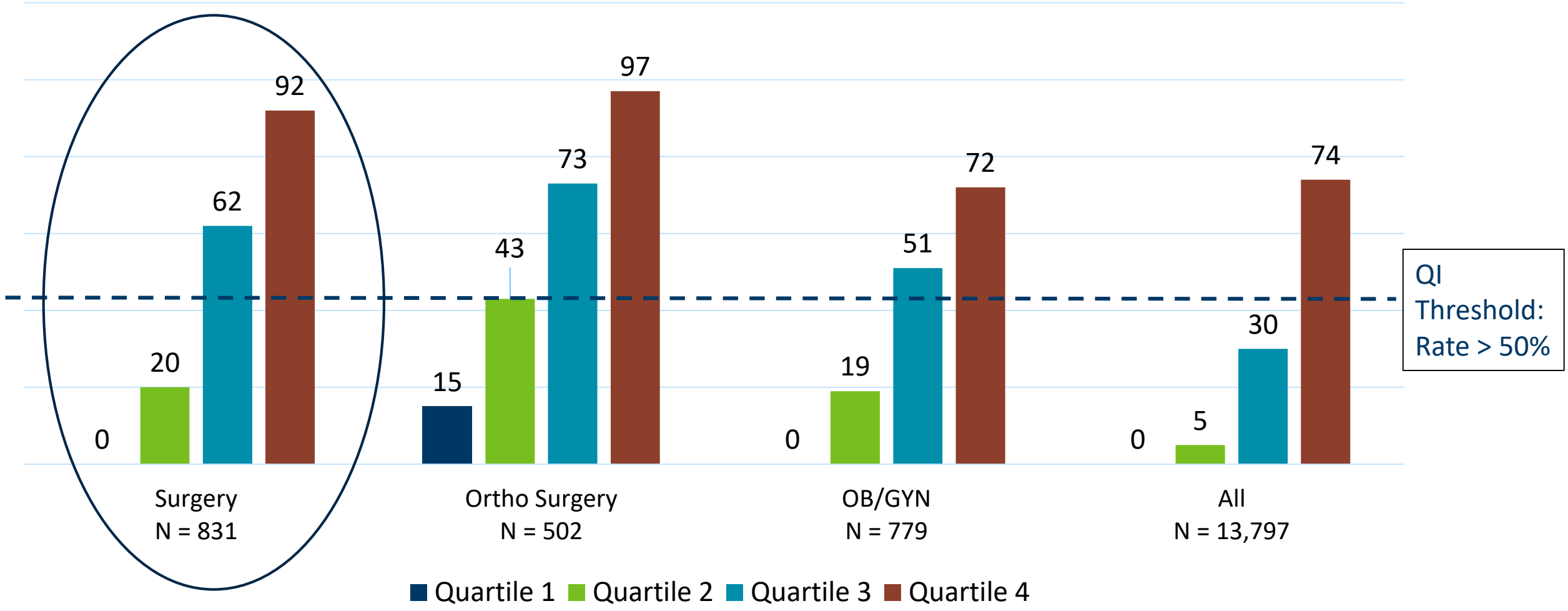
Prescribing Rate

$$\frac{\text{Number of index opioid prescriptions prescribed in the measurement period}}{\text{Total number of patients seen by the provider in the measurement period}}$$

Recommended Dose

$$\frac{\text{Number of index opioid prescriptions exceeding 100 MME (medical specialty) or 200 MME (surgical specialty) in the measurement period}}{\text{Total number of index opioid prescriptions prescribed in the measurement period}}$$

Percent of index opioid prescriptions that exceed 200 MME, by specialty (percentage = average within quartile)



Initial opioid prescribing episode:
Rate of exceeding 700 cumulative MME in the post-acute pain period

Cumulative MME Exposure

Number of prescriptions which cross the 700 cumulative MME threshold or exceed 700 cumulative MME prescribed in the measurement period

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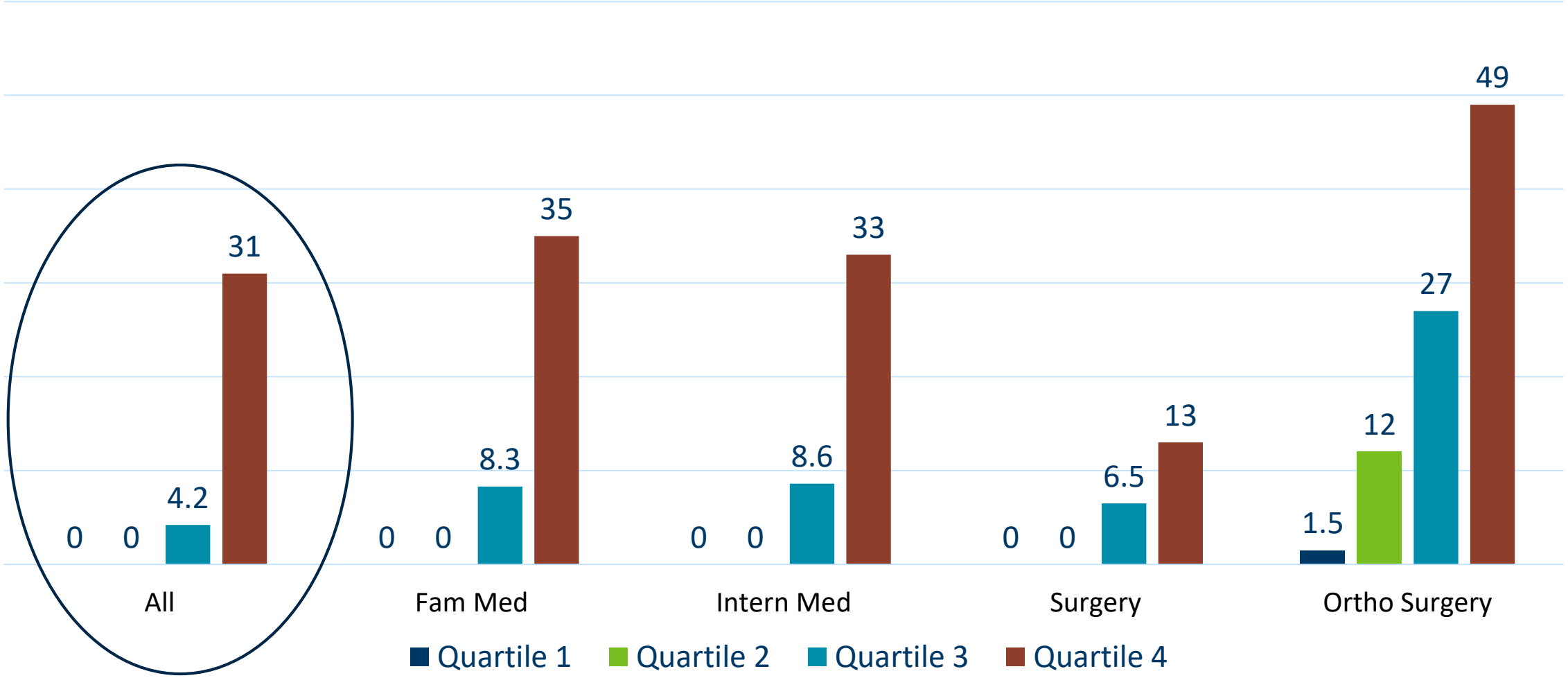
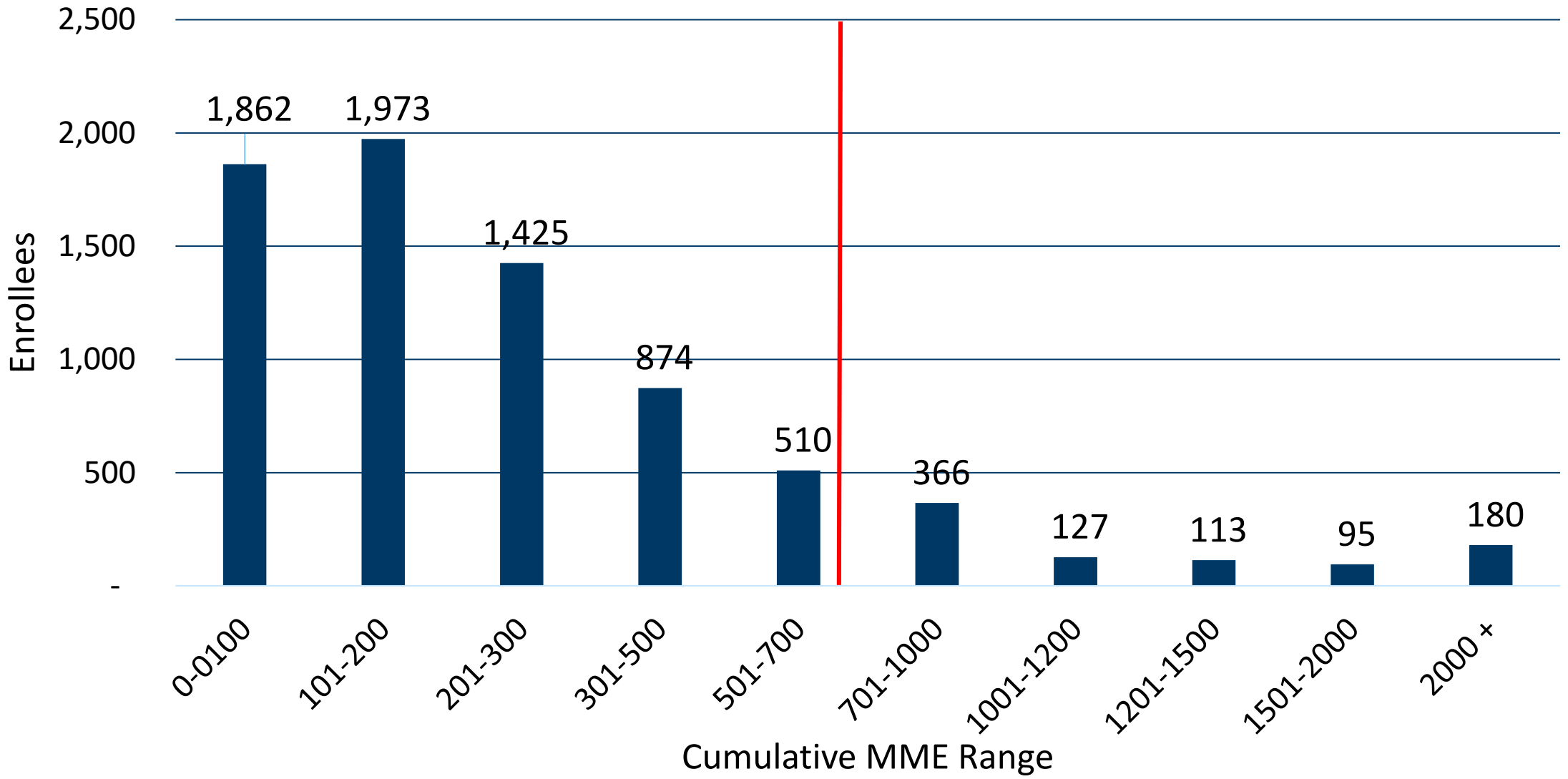
Number of opioid prescriptions prescribed during an initial opioid prescribing episode (index opioid prescription + 45 days) in the measurement period

Percent of opioid prescriptions in the post-acute pain interval that cross or exceed the 700 MME threshold, by specialty; 2016



Cumulative MME Exposure in Post-Acute Period: Internal Medicine



Chronic opioid analgesic therapy (COAT) prescribing rate

COAT Prescribing Rate

$$\frac{\text{Number of patients prescribed COAT in the measurement period}}{\text{Number of patients prescribed opioids in the measurement period}}$$

High-dose COAT prescribing rate

High-Dose COAT

$$\frac{\text{Number of patients prescribed COAT of} \geq 90 \text{ MME/day in the measurement period}}{\text{Number of patients prescribed COAT in the measurement period}}$$

Concomitant COAT and elevated-dose benzodiazepine therapy prescribing rate

Concomitant COAT and Benzodiazepines

Number of patients prescribed COAT of ≥ 50 MME/day and an overlapping benzodiazepine prescription > 7 days in the measurement year

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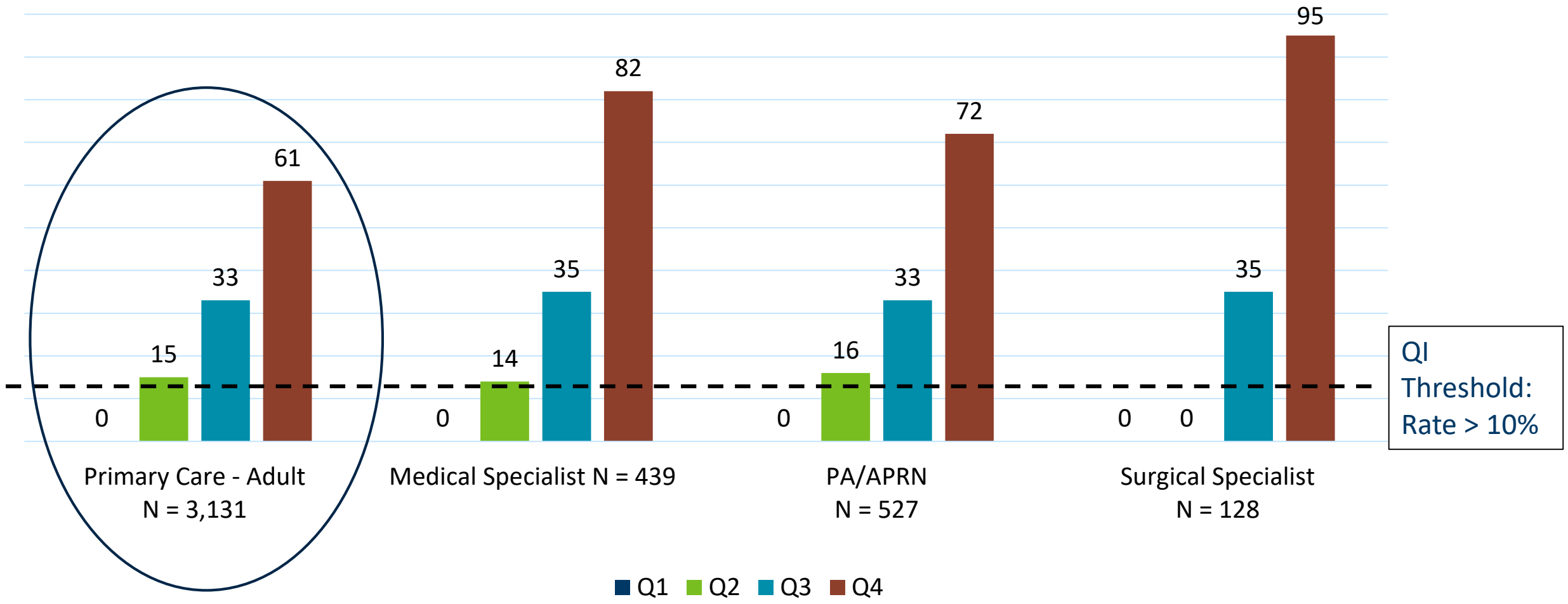
Number patients prescribed COAT in the measurement year

Percent of COAT enrollees receiving concomitant benzodiazepine prescriptions, by quartile within specialty; 2016 (percentage = average within quartile)



Percent of COAT patients receiving opioids from multiple prescribers

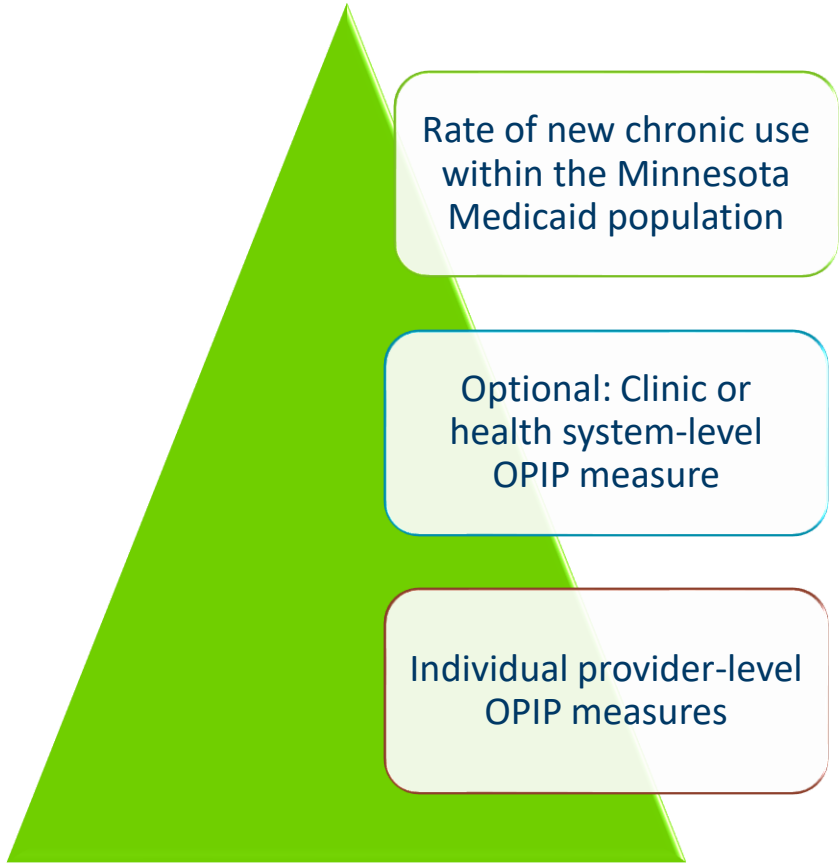
Multiple prescribers

$$\frac{\text{Number of patients on COAT receiving opioid prescriptions from 3+ prescribers during the measurement period}}{\text{Number of patients prescribed COAT during the measurement period}}$$

Multi-level measures of opioid prescribing behavior

Individual provider-level measures:

1. Index opioid prescription prescribing rate
2. Rate of prescribing over recommended dose limits
3. Rate of prescribing over 700 cumulative MME
4. Chronic opioid analgesic therapy (COAT) prescribing rate
5. Rate of prescribing high-dose COAT
6. Rate of prescribing concomitant COAT and benzodiazepines
7. Multiple prescriber (3+) measure for COAT patients



Provider report of prescribing behavior

- Annual report of prescribing behavior, compared to anonymized peers
  - First reports out Winter 2018 – no QI for the first set of reports
  - QI program will begin in 2019
- Individual prescriber data is subject to peer protected review
- Providers whose prescribing exceed the quality improvement threshold will be required to undergo a quality improvement process
  - Information will be shared with provider groups where the prescribed is affiliated
- Providers whose prescribing continually exceeds threshold or who show no improvement may be terminated from the MHCP programs

Quality improvement program

- Develop in partnership with the medical community
- Reconvene the OPWG in Winter 2018 to develop quality improvement process recommendations
- Partnership with the Minnesota Hospital Association:
  - Disseminate and implement prescribing guidelines
  - Disseminate and explain the quality improvement framework
  - Develop sample quality improvement templates

Opioid Prescribing Improvement Program: Quality improvement review

- Acute pain
  - Query the PMP
  - Demonstrate adherence to dosing recommendations
- Post-Acute Pain
  - Administer recommended screenings and assessments
  - Introduce multi-modal pain management strategies
  - Demonstrate adherence to dosing recommendations

Quality improvement review, continued

- Chronic opioid analgesic therapy
  - Query the PMP
  - Implement multidisciplinary approach to pain management
    - Medication therapy management
  - Initiate patient provider agreements
  - Administer recommended screenings and assessments
  - Demonstrate adherence to taper recommendations

Example: CHI St. Gabriel's Health Controlled Substance Care Team

- Multi-disciplinary Controlled Substance Care Team developed in 2015
  - Nurse navigator (care coordinator), social worker, mental health provider, pharmacist, physician
- Pharmacist's responsibilities include:
  - Design opioid taper plans to review with patients
  - Patient education
  - Suggest adjuvant medications to treat withdrawal symptoms
  - Help verify lab results from confirmatory testing
  - Direct link between care team and community pharmacy

Provider education

- Guideline podcast developed with the University of Minnesota Academic Health Center
- Resources developed in partnership with MHA
- “Flip the Script”
  - The primary goal is to develop consistent messages and language to use when talking to patients about pain and opioid use
  - Campaign is being developed in collaboration with the statewide media campaign on opioids
  - Campaign launch Summer/Fall 2018

Patient-centered **medically assisted treatment/recovery…**

Abstinence through buprenorphine, methadone, or naltrexone integrated with behavioral health interventions and recovery supports.

Patient-centered medically assisted recovery

- Behavioral health integration
- Induction and stabilization
- Ongoing medical management
- Review of progress
- Planned withdrawal

OUD Treatment

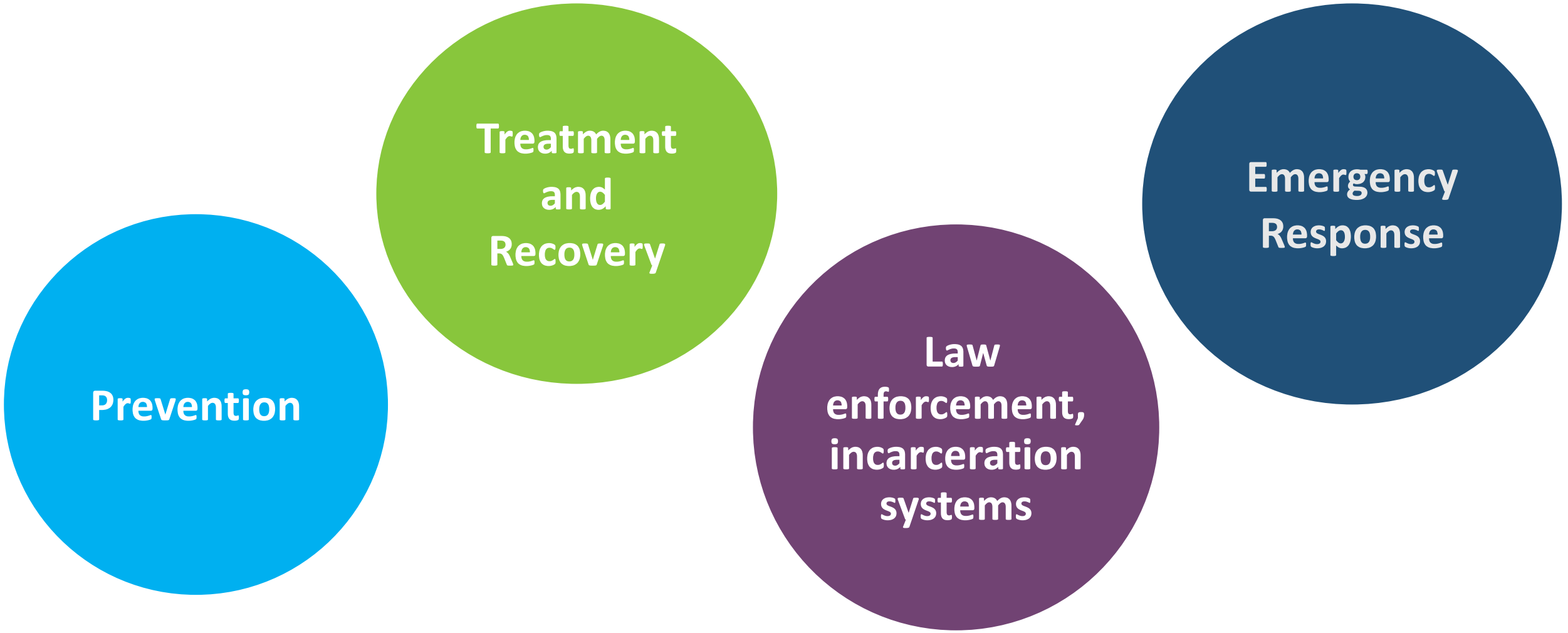
- Significant SUD reforms enacted in 2017
- MN Project ECHO
  - Tele-education model to disseminate specialty-based knowledge to primary care
  - Expand access and quality of medication-assisted treatment
- Grants to support infrastructure
  - Well-designed office-based opioid treatment
  - Culturally based, integrated care for pre- and post-natal care of women exposed to opioids

Medically assisted recovery, project ECHO

Meet need for OUD treatment

Geographic access

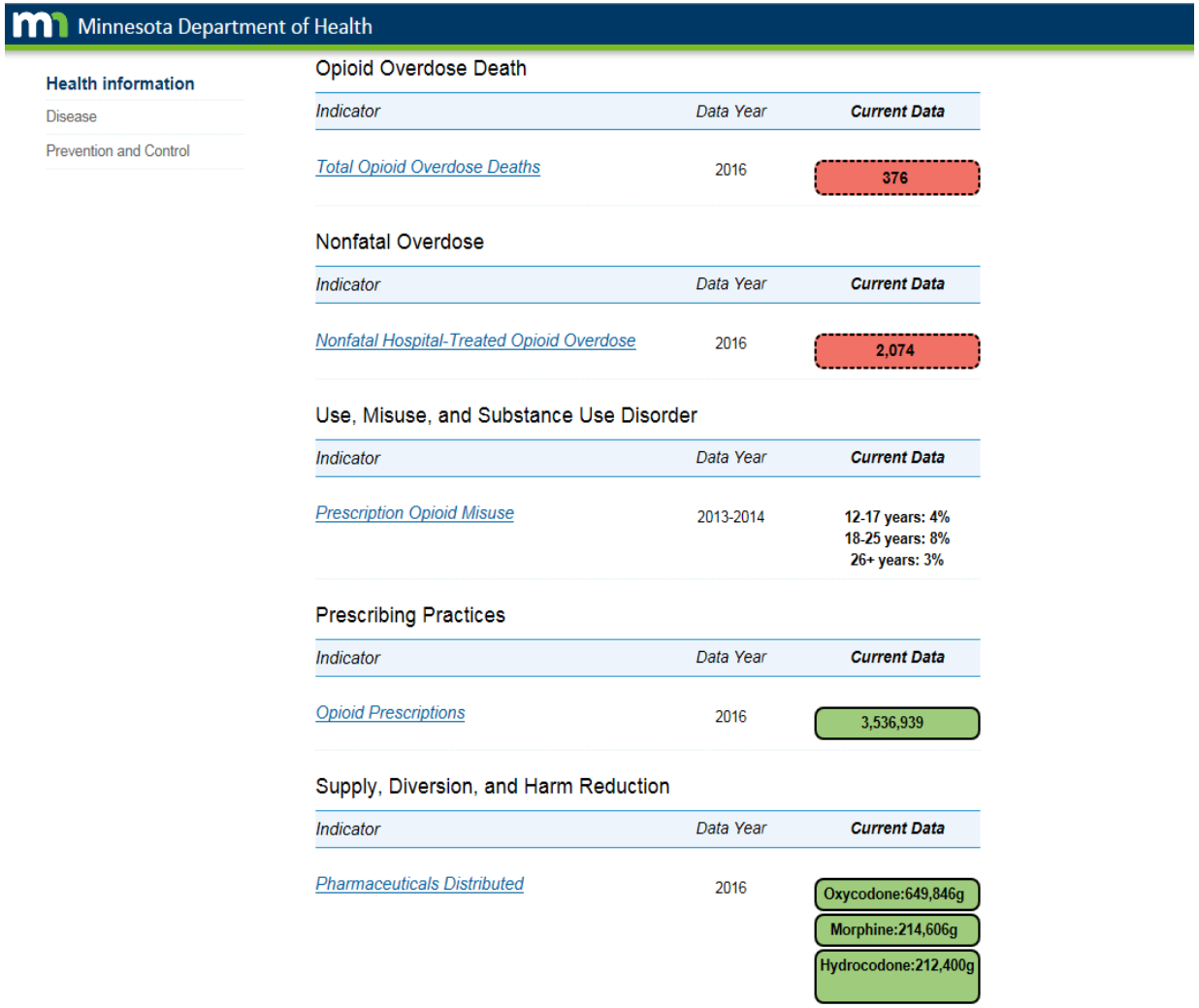
Access across every community



Moving forward

Strong, intentional integration of care and across sectors

Department of Health: Opioid Dashboard



Minnesota Department of Health

Health information

Disease

Prevention and Control

Opioid Overdose Death

Indicator	*Data Year*	***Current Data***
Total Opioid Overdose Deaths	2016	376

Nonfatal Overdose

Indicator	*Data Year*	***Current Data***
Nonfatal Hospital-Treated Opioid Overdose	2016	2,074

Use, Misuse, and Substance Use Disorder

Indicator	*Data Year*	***Current Data***
Prescription Opioid Misuse	2013-2014	12-17 years: 4% 18-25 years: 8% 26+ years: 3%

Prescribing Practices

Indicator	*Data Year*	***Current Data***
Opioid Prescriptions	2016	3,536,939

Supply, Diversion, and Harm Reduction

Indicator	*Data Year*	***Current Data***
Pharmaceuticals Distributed	2016	Oxycodone:649,846g Morphine:214,606g Hydrocodone:212,400g

- http://health.state.mn.us/opioiddashboard
- Provides the medical community and the public with up to date data on opioid overdose deaths, nonfatal opioid overdoses, prescribing data, treatment admissions, etc.
- Also provides links to numerous sources related to the opioid crisis
- Information provided on how to run the measures in your own health care system

Minnesota Department of Human Services Resources

- Opioid Prescribing Guidelines
  - https://mn.gov/dhs/opioid-guidelines/
- DHS General Opioid Web site: Overview of all DHS opioid-related efforts
  - https://mn.gov/dhs/opioids/
- Opioid public education campaign: Know the Dangers
  - http://knowthedangers.com/
- Fast-Tracker: Virtual community and health care connection resource for mental health and substance use disorder services
  - http://www.fast-trackermn.org/
- OPWG Web site: http://mn.gov/dhs/opwg

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Thank You!