Opioid Prescribing Improvement Program

Jeff Schiff, MD, MBA, Medical Director of Minnesota Health Care Programs
Sarah Rinn, MPH, Opioid Prescribing Improvement Program Coordinator
• How the guidelines advance Minnesota’s opioid efforts and relate to national opioid prescribing guidance

• Provider-level measures developed by DHS to support improvement across Minnesota

• How health care organizations can support the statewide quality improvement process that includes reporting of prescribing variation and outlier status

• Activities to support expansion of office-based treatment for opioid use disorder and best practices for neonatal opioid exposure
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

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
By FY2025, Minnesota would experience an annual budget shortfall of nearly $5 billion, which is equivalent to the projected cost of MA coverage for all parents and children. 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 for 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

<table>
<thead>
<tr>
<th>Year</th>
<th>45/90</th>
<th>90/180</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>5,266</td>
<td>4,156</td>
</tr>
<tr>
<td>2013</td>
<td>5,919</td>
<td>4,872</td>
</tr>
<tr>
<td>2014</td>
<td>5,965</td>
<td>4,672</td>
</tr>
<tr>
<td>2015</td>
<td>6,012</td>
<td>4,952</td>
</tr>
<tr>
<td>2016</td>
<td>4,952</td>
<td>3,706</td>
</tr>
</tbody>
</table>
Prevalence of mental health conditions and history of substance use disorders among new chronic users

2 year diagnostic history of new chronic opioid users
(Index period: 1/1/2013 – 6/30/2012)

- Mental Health: 81%
- Substance Abuse and Treatment: 30%
- Mental Health & Substance Abuse: 29%
Significant variation in prescribing both within and across provider specialty groups

Percent of opioid prescriptions prescribed 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

<table>
<thead>
<tr>
<th>Cumulative MME Range</th>
<th>Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-0100</td>
<td>1,862</td>
</tr>
<tr>
<td>101-200</td>
<td>1,973</td>
</tr>
<tr>
<td>201-300</td>
<td>1,425</td>
</tr>
<tr>
<td>301-500</td>
<td>874</td>
</tr>
<tr>
<td>501-700</td>
<td>510</td>
</tr>
<tr>
<td>701-1000</td>
<td>366</td>
</tr>
<tr>
<td>1001-1200</td>
<td>127</td>
</tr>
<tr>
<td>1201-1500</td>
<td>113</td>
</tr>
<tr>
<td>1501-2000</td>
<td>95</td>
</tr>
<tr>
<td>2000+</td>
<td>180</td>
</tr>
</tbody>
</table>
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.
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.
Key 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)
Key clinical recommendations:
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.

• Avoid prescribing more than 700 cumulative MME during the post-acute pain interval.

• 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
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
Key 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.
Why develop a distinct set of prescribing guidelines?

• Novel approach to post-acute pain period

• Need for statewide guidance

• Support quality improvement program in Minnesota Health Care Programs
OPIP Sentinel Measures and Prescribing Data
Overview of opioid prescribing data; Minnesota Health Care Program enrollees, 2016

- 691,516 opioid prescriptions
  - 146,983 Index Prescriptions
  - 66,547 additional Rx during post-acute period
  - 477,986 other Rxs (chronic, acute on chronic, etc)

- 1.2 million member years (approximately 1.2 million enrollees)
<table>
<thead>
<tr>
<th>Measure terms</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index opioid prescription</td>
<td>The first opioid prescription in the measurement period after at least 90 days of opioid naiveté</td>
</tr>
<tr>
<td>Opioid naïve user</td>
<td>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</td>
</tr>
<tr>
<td>Morphine milligram</td>
<td>The morphine equivalence of a specific opioid dose and formulation. The morphine equivalence is calculated using standard conversion ratios.</td>
</tr>
<tr>
<td>equivalence (MME)</td>
<td></td>
</tr>
<tr>
<td>Chronic opioid analgesic</td>
<td>A ≥ 60 consecutive days supply of opioids from any number of prescriptions. A ≤ 3 day gap is permissible between prescriptions</td>
</tr>
<tr>
<td>therapy (COAT)</td>
<td></td>
</tr>
<tr>
<td>High-dose COAT</td>
<td>A ≥ 60 consecutive days supply of opioids and the daily dose ≥ 90 MME.</td>
</tr>
<tr>
<td>Elevated-dose COAT</td>
<td>A ≥ 60 consecutive days supply of opioids and the daily dose ≥ 50 MME.</td>
</tr>
</tbody>
</table>
Index opioid prescription measures

**Prescribing Rate**

Number of index opioid prescriptions prescribed in the measurement period

Total number of patients seen by the provider in the measurement period

**Recommended Dose**

Number of index opioid prescriptions exceeding 100 MME (medical specialty) or 200 MME (surgical specialty) in the measurement period

Total number of index opioid prescriptions prescribed in the measurement period
Percent of index opioid prescriptions that exceed **100 MME**, by specialty (Percentage = Average within Quartile)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Combined Q3 &amp; Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Med</td>
<td>4</td>
<td>18</td>
<td>36</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>N = 951</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Med</td>
<td>12</td>
<td>51</td>
<td>70</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>N = 4,153</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Med</td>
<td>25</td>
<td>70</td>
<td>88</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>N = 1,670</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB/GYN</td>
<td>27</td>
<td>66</td>
<td>85</td>
<td>97</td>
<td></td>
</tr>
<tr>
<td>N = 779</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>6</td>
<td>44</td>
<td>85</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>N = 13,797</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

QI Threshold: Rate > 50%
Percent of index opioid prescriptions that exceed **200 MME**, by specialty (Percentage = Average within Quartile)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>N</th>
<th>Quartile 1</th>
<th>Quartile 2</th>
<th>Quartile 3</th>
<th>Quartile 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>831</td>
<td>20</td>
<td>62</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Ortho Surgery</td>
<td>502</td>
<td>15</td>
<td>43</td>
<td>73</td>
<td>97</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>779</td>
<td>0</td>
<td>19</td>
<td>51</td>
<td>72</td>
</tr>
<tr>
<td>All</td>
<td>13,797</td>
<td>0</td>
<td>5</td>
<td>30</td>
<td>74</td>
</tr>
</tbody>
</table>

QI Threshold: Rate > 50%

6/13/2018
Initial opioid prescribing episode:
Rate of exceeding 700 cumulative MME in the post-acute pain period

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

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 met or exceeded 700 MME, by specialty group: 2016
(Percentage = Average within quartile)

Primary Care
N = 6,294

Medical Specialists
N = 854

Surgery
N - 1,517

Ortho Surgery
N = 534

Quartile 1
Quartile 2
Quartile 3
Quartile 4

QI Threshold:
Rate > 15%
Chronic opioid analgesic therapy (COAT) prescribing rate

COAT Prescribing Rate

Number of patients prescribed COAT in the measurement period

Number of patients prescribed opioids in the measurement period
Percent of enrollees who received at least one opioid who were prescribed COAT, by quartile within provider specialty group; 2016 (Percentage = Median within quartile)

<table>
<thead>
<tr>
<th>Specialty Group</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care - Adult</td>
<td>0</td>
<td>0</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>Medical Specialist</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>PA/APRN</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Surgical Specialist</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

No quality improvement threshold

Primary Care - Adult: N = 7,142
Medical Specialist: N = 3,016
PA/APRN: N = 2,063
Surgical Specialist: N = 1,990
High-dose COAT prescribing rate

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

Number of patients prescribed COAT in the measurement period
Percent of COAT enrollees who received high-dose COAT (> 90 MME/day), by quartile within provider specialty group; 2016 (Percentage = Median with quartile)

Primary Care - Adult  
N = 3,130

Medical Specialist  
N = 439

PA/APRN  
N = 527

Surgical Specialist  
N = 128

Q1
Q2
Q3
Q4

0 0 0 0
10 4 3 0
29 25 25 50

Threshold: Rate > 10%
Concomitant COAT and elevated-dose benzodiazepine therapy prescribing rate

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

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)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>N</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care - Adult</td>
<td>3,131</td>
<td>0</td>
<td>15</td>
<td>61</td>
<td>33</td>
</tr>
<tr>
<td>Medical Specialist</td>
<td>439</td>
<td>0</td>
<td>14</td>
<td>82</td>
<td>35</td>
</tr>
<tr>
<td>PA/APRN</td>
<td>527</td>
<td>0</td>
<td>16</td>
<td>72</td>
<td>33</td>
</tr>
<tr>
<td>Surgical Specialist</td>
<td>128</td>
<td>0</td>
<td>0</td>
<td>95</td>
<td>35</td>
</tr>
</tbody>
</table>
Percent of COAT patients receiving opioids from multiple prescribers

- Number of patients on COAT receiving opioid prescriptions from 3+ prescribers during the measurement period
- Number of patients prescribed COAT during the measurement period
### Percent of COAT enrollees receiving opioids from 3+ prescribers, by quartile within specialty group; 2016

(Percentage = Average within quartile)

<table>
<thead>
<tr>
<th>Specialty Group</th>
<th>N</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>No quality improvement threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care - Adult</td>
<td>3,130</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>27</td>
<td>6/13/2018</td>
</tr>
<tr>
<td>Medical Specialist</td>
<td>439</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>PA/APRN</td>
<td>527</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Surgical Specialist</td>
<td>128</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>62</td>
<td></td>
</tr>
</tbody>
</table>

6/13/2018
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

Rate of new chronic use within the Minnesota Medicaid population
Optional: Clinic or health system-level OPIP measure
Individual provider-level OPIP measures
Provider report of prescribing behavior

• Annual report of prescribing behavior, compared to anonymized peers

• Reports will be sent out electronically

• 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
Draft version of prescriber reports
Prescriber education campaign

• “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 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
Meet need for OUD treatment

Geographic access

Access across every community
Moving forward
Strong, intentional integration of care and across sectors
State Targeted Response Grants

• Naloxone distribution
• Integrated Care for High-Risk Pregnancies project
• Peer recovery support specialists
• Parent Child Assistance Program
• Extension for Community Healthcare Outcomes (ECHO)
• Office Based Opioid Treatment
Leadership priorities

- Implement *prescribing* and SUD improvement plan
- Ensure *culturally-sensitive, targeted prevention efforts*
- Move toward *integrated care*
- Offer access to *life-saving overdose medication*
- Improve *treatment in correctional facilities*
Department of Health: Opioid Dashboard

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
• 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
Thank You!