Opioid Prescribing Improvement Program

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Minnesota Injury Prevention Alliance Meeting

November 29, 2017

DEPARTMENT OF HUMAN SERVICES

Agenda

- Brief overview of Opioid Prescribing Improvement Program (OPIP)
- Opioid prescribing guidelines
- Next steps

Opioid Prescribing Improvement Program (OPIP)

- Authorized in the 2015 legislative session: Minnesota Statute § 256B.0638
- Four program components:
  1. Opioid Prescribing Work Group (OPWG)
  2. Opioid Prescribing Guidelines (statewide)
  3. Opioid prescribing quality improvement program for Minnesota Health Care Program-enrolled providers (MHCP-enrolled providers only)
  4. Prescriber education campaign (statewide)

OPIP: Where we got started

- 2015 analysis of Minnesota Health Care Program (MHCP) enrollees' opioid use
- 80% of previously opioid naïve people who had a 45-day supply of opioids over 3 months went on to receive a 90-day supply of opioids in the year
- National estimates indicate that 65% of people with a 90 day supply are still taking opioids **three years later**
- Characteristics of new chronic opioid use population
  - 80% had mental health conditions, substance abuse history or both

Where can MN take a stand? Prevent the progression to chronic opioid use

Addressing chronic opioid use and prescription opioid-related morbidity and mortality

- Prevention
  - Acute and post-acute pain
  - In all health care settings
- Chronic pain management
  - Optimal dosing, access to non-opioid therapies, opportunities to taper
- Treatment for addiction
  - Expanded access to evidence-based treatments (MAT/OBOT)

Opioid Prescribing Work Group

- DHS issued notice to apply for members in June 2015
- OPWG membership categories provided in statute:
  - Physician, nurse practitioner, pharmacist, dentist
  - Non-physician health care professionals (2)
  - Mental health professional
  - Health plan medical director and health plan pharmacy director
  - Medical examiner
  - Member of DHS Health Services Advisory Council
  - Consumer representatives (2)
  - Law enforcement
  - MDH, DLI, DHS representatives (non-voting)

OPWG charged with recommending the following:

- Common opioid prescribing protocols
  - Acute pain (0-4 days, up to 7 days following surgery)
  - Post-acute pain (up to 45 days)
  - Chronic pain (>45 days)
- Educational messages for prescribers to give to patients

OPWG charge, continued

- Sentinel measures for each prescribing period
  - DHS will report data to enrolled providers (not public)
- Criteria for mandatory quality improvement among MHCP-enrolled providers
  - Criteria based on recommended sentinel measures for each prescribing period
  - Outliers develop and report QI to DHS
- Criteria for terminating providers from MHCP

Key principles for prescribing recommendations: Prevention

1. Prescribe the lowest effective dose and duration of opioid analgesia when an opioid is 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 opioid use during this period.

Growing body of evidence supports relationship between initial opioid exposure and risk of long-term use

- Shah et al. found that the probability of long-term opioid use is related to
  - Number of days supply of the first opioid prescription
  - Number of prescriptions in the first episode of opioid use
  - Initial total dose of the first episode of opioid use
- Miech et al. found that legitimate opioid use before high school graduation is independently associated with a 33% increase in the risk of future opioid misuse after high school.
- Brummett et al. found that new persistent opioid use after surgical procedures was 5.9 to 6.5% and did not differ between major and minor surgeries.

Evidence also supports increased assessment of mental health conditions

- Davis et al found that the 16% of Americans who have mental health disorders receive half of all opioids prescribed.
- Among MHCP enrollees who transition to chronic opioid use:
  - 81% had a mental health condition diagnosis within past 2 years
  - 30% had a claim for substance abuse treatment within past 2 years
  - 29% had both

Key clinical points from the acute pain phase recommendations

- Avoid prescribing more than a three day supply or 20 pills of low-dose, short-acting opioids. Limit the entire prescription to 100 morphine milligram equivalents (MME).
- Limit the initial acute prescriptions to no more than 7 days or up to 200 MME, unless circumstances clearly warrant additional opioid therapy. Limit the entire prescription to 200 MME.
- Check the Prescription Monitoring Program (PMP) to review the patient's prescribing history whenever prescribing an opioid for acute pain.

Key clinical recommendations from the post-acute pain prescribing guidance

- Assess and document risk factors, including depression, anxiety, substance abuse, fear avoidance and pain catastrophizing throughout the post acute pain period.
- Prescribe opioids in multiples of 7 days, with no more than 200 MME per 7 day period, and no more dispensed than the number of doses needed.
- Avoid prescribing more than 700 cumulative MME during the post-acute pain period.
- Develop a referral network for mental health, substance use disorder, pain education and pain medicine.

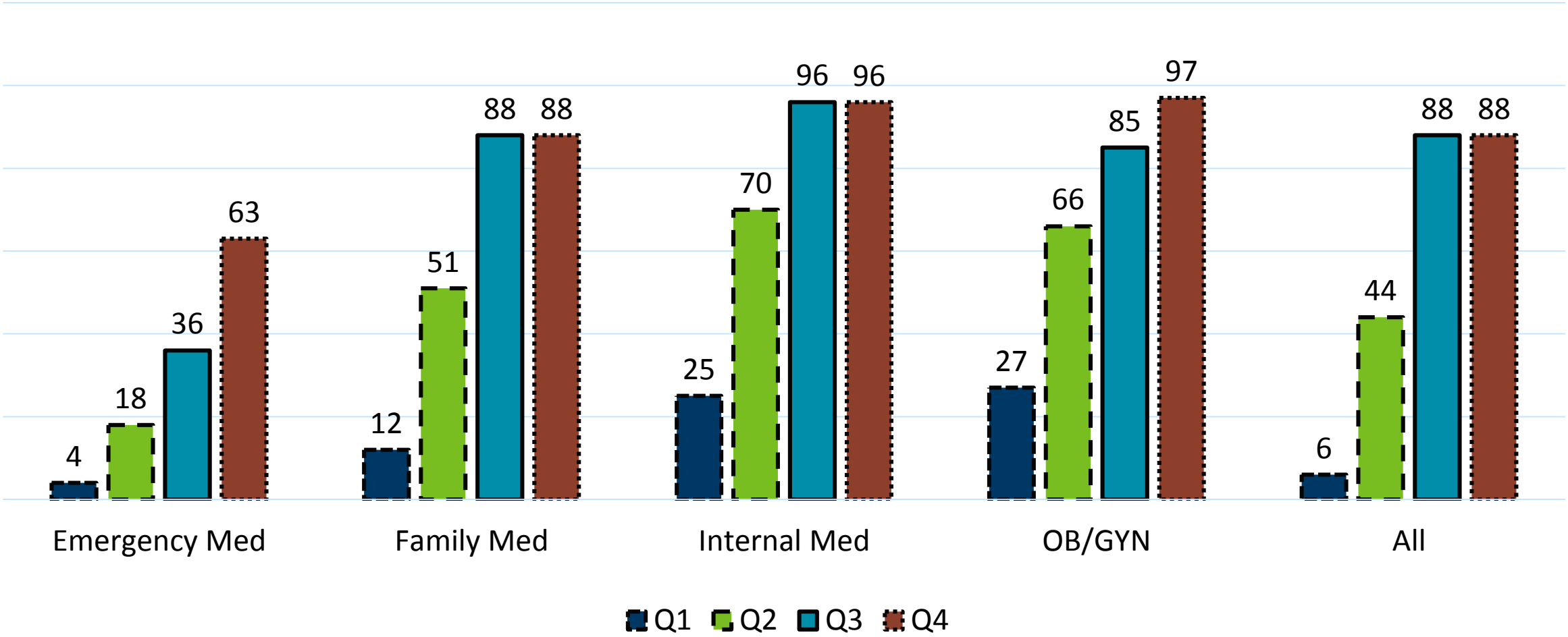
Key principle for prescribing recommendations: Harm reduction

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 and carefully manage those who remain on opioid medication.

Key clinical recommendations from the chronic pain guidance

- 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 early and often – at least every 3 months.

Significant variation in prescribing behavior among Minnesota prescribers



Quality improvement program for MHCP-enrolled providers

- Opioid prescribing sentinel measures
- Annual provider report of prescribing behavior
- Quality improvement review

Draft version of prescriber reports

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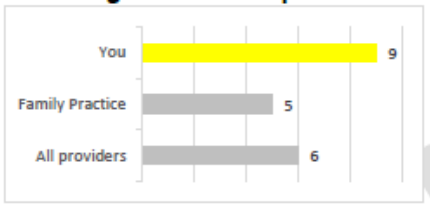
Report Key	
	Below the mean of specialty
	Above the mean of specialty
	Above threshold (TBD)

Your 2016 Prescribing Report **For OPWG Discussion ONLY**

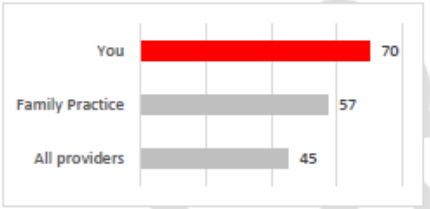
As part of the Minnesota Health Care Program's ongoing efforts to ensure safe and effective care for its enrollees, this report compares your opioid prescribing to that of other providers treating enrollees in 2016. Using MHCP administrative claims data, this report looks at three phases of the pain prescribing cycle: 1) index opioid prescriptions; 2) all opioid prescriptions written from the date of the index opioid prescription to 45 days later; and 3) chronic opioid use.

Your peer group was identified as **Family Practice.** DHS created peer comparison groups based on the primary taxonomy identified with your National Provider Identification number. If your practice type is not consistent with your taxonomy, please visit [NPES website] to make that change.

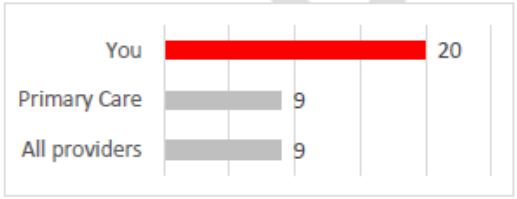
Percentage of enrollees prescribed an index opioid prescription



Percent of index opioid prescriptions that exceed recommended dosage (100 MME)



Number of opioid prescriptions you wrote within 6 weeks of an index opioid prescription that exceeded 700 cumulative morphine milligram equivalence 26



Percent of enrollees prescribed High-Dose Opioids among all enrollees on COAT

25	Number of enrollees prescribed COAT	12	Number of enrollees receiving concomitant opioids and sedatives	6	Number of enrollees on COAT receiving opioids from 4+ providers (including you)

Telephone: 800-xxx-xxxx | Email: dhs.opioid@state.mn.us | Website: www.mn.gov/opwg

References

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Thank You!

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