Opioid Prescribing Improvement Program

Office of the MHCP Medical Director

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Minnesota Department of **Human Services**

Legislative Report

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I. Executive summary

The Minnesota Legislature established the Opioid Prescribing Improvement Program (OPIP) in 2015. The aim of the OPIP is to reduce opioid dependency and substance use by Minnesotans due to the prescribing of opioid analgesics by health care providers. This will be accomplished by developing statewide guidelines on appropriate opioid prescribing for acute pain, post-acute pain and chronic pain; developing educational resources for providers for communicating to patients about pain; and implementing an opioid prescribing quality improvement program among Minnesota Health Care Program-enrolled providers whose prescribing behaviors are found to be outside of community standards.

In this annual report we:

- Provide a progress update on the Opioid Prescribing Work Group's work plan and work completed to date;
- Provide key points from the draft Acute Pain Prescribing Recommendations and Post-Acute Prescribing Recommendations;
- Provide an update on the OPIP opioid prescribing sentinel measure development and MHCP Quality Improvement Program; and
- Provide a brief summary of how the OPIP complements other state agency initiatives to address opioid dependency and substance abuse.

The Department of Human Services (DHS) is committed to transforming prescribing practice via the transparent, and community-led focused structure of the OPIP. This year we focused primarily on developing and supporting the Opioid Prescribing Work Group (OPWG), our legislatively mandated expert panel, ensuring that the recommendations put forth by the work group represent the voice of the health care community. The work group is on track to complete the opioid prescribing recommendations by the end of 2016. The focus of the work group will then turn to recommending measures of appropriate opioid prescribing, developing educational resources, and recommending components of the Minnesota Health Care Program (MHCP) quality improvement program.

Community participation is steady at the monthly OPWG work group, and DHS provides opportunities for public comment on each of the OPIP components.

All of this work moves us closer to reducing the number of residents who become new chronic opioid users, reducing the health care utilization costs associated with opioid dependency and substance abuse, and most important, reducing the devastation in Minnesota communities related to opioid dependency and addiction.

II. Legislation

Minnesota Statutes 2015, section 256B.0638, subdivision 7: MINN. STAT. 256B.0638 (2015);

Subdivision 7. **Annual report to the legislature.** By September 15, 2016, and annually thereafter, the commissioner of human services shall report to the legislature on the implementation of the opioid prescribing improvement program in the Minnesota health care programs. The report must include data on the utilization of opioids within the Minnesota health care programs.

III. Introduction

Opioid dependency and abuse is a significant public health concern in Minnesota. Drug overdose deaths in Minnesota increased 11 percent from 2014 to 2015. Of the 572 total drug overdose deaths, 216 residents died from an overdose related to prescription opioid analgesics, and 115 died from a heroin overdose.[1]

The increase in opioid-related overdose deaths over the last decade is related to the significant increase in opioid prescribing over the same period. Sales of prescription opioids in the U.S. nearly quadrupled from 1999 to 2014. In 2012, providers wrote 259 million opioid prescriptions – enough for every American to have their own bottle of pills.[2] The role of prescribers in the current epidemic of opioid use has become a key focus of prevention efforts. Increased attention to prescribing behaviors from government entities, professional associations and other stakeholders appears to be having a positive effect on prescribing.

The Opioid Prescribing Improvement Program (OPIP) authorized by Minn. Stat. § 256B.0638 is an initiative to reduce opioid dependency and substance use by Minnesotans enrolled in Minnesota Health Care Programs (MHCP)—dependency and substance abuse that are related to the prescribing of opioid analgesics by health care providers.. The Commissioner of Human Services oversees the OPIP in collaboration with the Commissioner of Health. Its core components are grounded in community input via an expert work group: the Opioid Prescribing Work Group (OPWG). The OPWG convened in November 2015 for a two-year commitment to perform its legislatively set tasks:

- Recommending protocols that address all phases of the opioid prescribing cycle
- Overseeing development of educational resources and messages for providers to use in communicating with patients about pain and the use of opioids to treat pain
- Recommending quality-improvement measures to assess variation and support improvement in clinical practice
- Recommending two thresholds directed at MHCP-enrolled providers with persistently concerning prescribing practices, one threshold that will trigger quality improvement and the other termination from MHCP

Pursuant to the authorizing statute, the opioid prescribing protocols will not apply to opioids prescribed for patients who are experiencing pain caused by a malignant condition or who are receiving hospice care, or to opioids prescribed as medication-assisted therapy to treat opioid dependency.

[1] Minnesota Department of Health. Injury and Violence Prevention Unit. Drug overdose deaths among Minnesota residents: 2000-2015. Available at: http://www.health.state.mn.us/divs/healthimprovement/data/reports/drugoverdose.html . Accessed July 10, 2016.

[2] Center for Disease Control and Prevention. Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines — United States, 2012. MMWR 2014; 63(26);563-568.

While the OPWG carries out its legislatively set work, DHS staff will develop a reporting mechanism for protected quality improvement data pertaining to the OPIP. Limited funding is available for protocol development support, refining quality improvement measures and developing educational messages.

The OPIP is a unique community supported effort to improve prescriber practice via a community-wide improvement process tied to Medicaid provider enrollment. The OPIP aims to balance the evidence for the use of opioids to treat pain with the inherent risks that these medications pose to individuals and communities.

IV. Opioid Prescribing Work Group Progress Update

The Department of Human Services, in collaboration with the Department of Health, convened the Opioid Prescribing Work Group (OPWG) in November 2015, with representation as stipulated in the legislation (Appendix A lists the full membership of the OPWG). The OPWG met monthly in 2016, and will continue to do so in 2017 in order to fulfill its mandate.

The OPWG is on schedule to complete the prescribing protocols by the end of 2016. According to the approved initial work plan, the OPWG focused on developing the opioid prescribing protocols in 2016 in this order: acute pain, post-acute pain, and chronic pain (See Appendix B for the OPWG Work Plan). Once the draft prescribing recommendations are complete, the OPWG will have the opportunity to synthesize the complete set of recommendations prior to submitting them to the Commissioner for approval. Highlights from the draft acute pain and post-acute pain prescribing recommendations are included in this report. The OPWG will vote on the draft post-acute pain recommendations during the September 2016 meeting and begin developing the chronic pain prescribing recommendations.

Work group members recommended opioid prescribing measurement domains (e.g., number of pills, morphine milligram equivalents per prescription) for acute pain in order for DHS to initiate development of the opioid prescribing sentinel measures. DHS staff are currently working on analysis of the recommended domains. Measurement development will begin in 2017 once the protocols are completed.

All OPWG meetings are public, and non-members may choose to attend and submit comments in person or by webcast. Community participation in the OPWG meetings has been steady. On average, 10 non-members attend the monthly meetings in person, and the average number of online participants is 36. Non-member participants include state government employees, health care providers, community members, and pharmaceutical industry representatives.

The OPWG's web page is www.dhs.state.mn.us/opwg. DHS staff maintain a dedicated email address for communications pertaining to the OPWG: dhs.opioid@state.mn.us. Community members may request to be added to the OPWG email distribution list in order to receive information about upcoming meetings, meeting materials, and notification of public comment periods.

A. Opioid Prescribing Protocols

As noted above, the OPWG is working on prescribing protocols for acute pain, post-acute pain, and chronic pain in that order. None of the recommendations will be considered final until the OPWG considers all of the protocols together as a group and refines them as necessary for internal consistency after all three drafts are combined.

The OPWG completed the draft acute pain prescribing recommendations in March 2016. DHS held a public comment period in June 2016, and received comments from 10 entities. The work group reviewed all of the comments, and revised portions of the recommendations.

Below are key clinical points from the draft acute pain opioid prescribing recommendations:

- Document patient's presentation of pain and diminished physician function.

- Consider any relevant opioid-related risk factors not already documented in the patient's record. Assess and document suicidality in every setting for every initial opioid prescription. Review medications and provide a brief screening for substance use disorder.

- Prescribers should check the Prescription Monitoring Program (PMP) whenever prescribing an opioid for acute pain.

- 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).

- Some surgical procedures and traumatic injuries require greater pain management. Prescribe no more opioids than will be needed for initial tissue recovery, usually no more than seven days or up to 200 MME. Manage acute post-operative pain in opioid tolerant patients, and provide opioid-tolerant patients no less treatment than opioid naïve patients.

- Do not prescribe opioids without an examination and diagnosis of the underlying reason for tooth pain by a dental provider. Surgical prescribing recommendations apply to patients undergoing dental extractions or other invasive procedures.

- Patients receiving chronic opioids who have an identifiable new injury or who undergo a procedure should receive the same dosage as patients not already on opioids (3 days/20 pills/100 MME). Do not increase opioid dosage for acute pain in patients receiving chronic opioids without a verifiable new injury.

- Avoid prescribing opioids to patients with a history of substance use disorder, and to those with an active addiction. If opioids are necessary, use extreme caution, frankly discuss the risks with the patient, and plan for close follow-up.

- Consult with a prescriber or pharmacist specifically trained in the pharmacology of buprenorphine or naltrexone when prescribing opioid analgesia to a patient receiving either medication for opioid use disorder.

- Avoid prescribing concurrent, new prescriptions of opioids and benzodiazepines or other sedative-hypnotic medications.

- Use caution when prescribing opioids to patients already using benzodiazepines or other sedative-hypnotic medications on an on-going basis.

- Avoid prescribing opioids for 1) fibromyalgia; 2) headache, including migraine; 3) self-limited illness, e.g. sore throat; 4) uncomplicated back and neck pain; and 5) uncomplicated musculoskeletal pain.

- Avoid prescribing opioids to pregnant women. Assess pregnancy risk in all women of childbearing age prior to prescribing an opioid. Follow post-surgical recommendations when prescribing opioids for women following a cesarean section.

- Provide proper pain control to lactating women experiencing acute pain following birth and surgical procedures. If pain medication is indicated, use non-opioid pain relievers and avoid prescribing opioids when possible.

- Acute dosing for children should be proportional by weight to the dosing guidance for adults (3 days/20 pills/100 MME for total prescription). Screen all children over the age of 10 for opioid-related risk factors. Prescribers should check the PMP for all children prescribed an opioid for acute pain, in order to confirm that the child is not at risk for parental diversion of the opioid. Avoid prescribing codeine in any setting given the high risk posed to ultra-fast metabolizers.

The OPWG will vote on the draft post-acute pain prescribing recommendations at the September 2016 meeting and there will be an opportunity for public comment in October. DHS will include key points from the post-acute pain opioid prescribing recommendations after the group votes in September.

B. Opioid Sentinel Measure Development

The OPWG recommended specific measurement domains to DHS in order for DHS staff to begin analyzing opioid prescribing behavior in the acute pain phase. The OPWG recommended that morphine milligram equivalence (MME) and number of tablets prescribed inform development of the acute pain sentinel measure. (MME measures convert different forms of opioid prescription drugs into a common unit for the purpose of comparison.)

For the initial analysis of opioid prescribing behavior following acute painful events, DHS staff analyzed prescriptions written to opioid naïve MHCP enrollees following a subset of surgical procedures and injuries in federal fiscal year 2015. Definitions included in the analysis are provided below:

- Opioid naïve: No opioids prescribed within 90 days of the initial opioid prescription.

- Acute event: A prescription was included in the analysis if the enrollee met the definition of opioid naïve and one of the following events occurred within 7 days of the prescription:

    - Obstetric surgery

- Cardiac surgery
- Severe injury; and
- Dental surgery.

DHS staff is in the process of analyzing opioid prescriptions following the acute events listed above. Preliminary data and staff analysis of the potential utility and pitfalls of the measures proposed by the OPWG are being shared with the OPWG as it works to refine its recommendations about measurement. Reports to the legislature in future years will contain baseline and progress data gathered with the final, recommended measures.

V. Minnesota Health Care Program Quality Improvement Program

Pursuant to the legislation, DHS will create an opioid prescribing quality improvement program for MHCP-enrolled providers. MHCP-enrolled providers whose opioid prescribing exceed the thresholds to be determined by the OPWG will be required to submit quality improvement plans. The OPWG will begin work on the threshold recommendations once the sentinel measures have been developed.

DHS completed an initial analysis of a proposed methodology for developing provider peer groups in July 2016. Minn. Stat. 256B.0638, Subd.4 requires the commissioner to annually collect and report to opioid prescribers data showing the sentinel measures of their opioid prescribing patterns compared to the anonymized peers. DHS proposes using the National Provider Identifier (NPI) specialty taxonomy codes to group MHCP-enrolled providers into peer groups. Further refinement and analysis of the methodology will take place in late 2016 and into 2017.

VI. State Agency Efforts to Address Opioid Dependency and Addiction

Minnesota is facing the opioid crisis with multiple efforts and a high-level of coordination. Statewide efforts focus on moving as far upstream as possible, with the goal of decreasing excessive opioid prescribing, providing medications in our communities to treat overdoses, and improving access to treatment for those who have become addicted. State agencies collaborate on this work through the Minnesota State Substance Abuse Strategy (SASS). The SASS was developed in 2012 under the leadership of DHS, and in partnership with the departments of Education, Health, Public Safety, Corrections, Military Affairs, the state judicial branch, Minnesota National Guard and Minnesota Board of Pharmacy. The State Opioid Oversight Project (SOOP) coordinates the comprehensive interagency efforts.

State Opioid Oversight Project

The State Opioid Oversight Project (SOOP) work group meets monthly and helps unify efforts from state agencies and prescribing boards to maximize their effectiveness. The SOOP agencies and boards are currently reviewing the National Governor's Association "Finding Solutions to the Prescription Opioid and Heroin Crisis: A Road Map for States" document to determine state entity alignment and opportunities to present to the commissioners at the September State Substance Abuse Strategy meeting. The SOOP focuses on seven strategies that address multiple facets of the opioid crisis:

- Reducing Neonatal Abstinence Syndrome and improving maternal care through expanded treatment, services, and supports for pregnant women and substance-exposed infants;
- Improved access to medication-assisted recovery;
- Improve provider access to the Prescription Monitoring Program (PMP);
- Improved distribution of naloxone, the opioid overdose reversal agent;
- Primary prevention, focused on direct communications with prescribing providers when opioid prescriptions are first written and when prescriptions are continued;
- Improvement in opioid prescribing, through the OPIP; and
- Improved access to disposal for prescription opioids.

Specific DHS efforts to address opioid dependency and addiction include:

- The Alcohol and Drug Abuse Division (ADAD) has applied for three federal grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) to address the opiate epidemic. If awarded, the grants will support the following efforts: 1) strategic prevention framework for prescription drugs; 2) targeted capacity expansion for medication-assisted treatment; and 3) preventing prescription drug and opioid over-dose related deaths.

- The Health Care Administration's Unified Pharmacy Prescribing (UPPW) group implements common quantity limits and utilization management criteria for high impact and high cost drugs of potential misuse and abuse (including opioids) in all Minnesota Health Care Programs. The UPPW members include pharmacy policy

experts from DHS, Blue Cross Blue Shield, UCare, HealthPartners, Itasca Medical Care, Medica, Prime West, South Country Health Alliance and Metropolitan Health Plan. In 2015, the UPPW implemented policy that limits opiate prescriptions to a maximum dose of 120 MME/day. Payers grant exceptions through prior authorization in circumstances such as cancer-related pain, palliative care or documented medical necessity.

- The Health Care Administration's Integrated Care for High Risk Pregnant Women (ICHRP) grant program targets pregnant Medical Assistance enrollees residing in geographical areas identified as being above-average risk for prenatal opiate exposure.

VII. Appendix A. Opioid Prescribing Work Group Members

Work group members (and their statutorily set membership categories) are:

- Chris Johnson, MD (Chair), Allina Health (Health Services Advisory Council member)
- Julie L. Cunningham, PharmD, BCPP, Mayo Clinic Health System (nonphysician health care professional who treats pain)
- Senator Chris Eaton, RN, Minnesota State Senate (consumer representative)
- Tiffany Elton, PharmD, NCPS, Fond du Lac Human Services Pharmacy (pharmacist)
- Dana Farley, MS, Minnesota Department of Health (nonvoting)
- Rebekah Forrest, RN, CNP, Native American Community Clinic (nurse practitioner)
- Ifeyinwa Nneka Igwe, MD, Essentia Health (physician)
- Ernest Lampe, MD, Minnesota Department of Labor and Industry (DLI medical consultant; nonvoting)
- Matthew Lewis, MD (not practicing), Winona (consumer representative)
- Pete Marshall, PharmD, HealthPartners (health plan pharmacy director)
- Murray McAllister, PsyD, LP, Courage Kenny Rehabilitation Institute (nonphysician health care professional who treats pain)
- Richard Nadeau, DDS, MPH, University of Minnesota School of Dentistry (dentist)
- Mary Beth Reinke, PharmD, MSA, Department of Human Services (DHS pharmacy unit; nonvoting)
- Charles Reznikoff, MD, Hennepin County Medical Center (mental health professional)
- Alvaro Sanchez, MD, Medica (health plan medical director)
- Jeffrey Schiff, MD, MBA, Minnesota Department of Human Services (MHCP medical director; nonvoting)
- Sgt. Matthew J. St. George, Minneapolis Police Department (law enforcement)
- Lindsey Thomas, MD, Hennepin County Medical Examiner's Office (medical examiner)

VIX. Appendix B. Opioid Prescribing Work Group Work Plan