DEPARTMENT OF HUMAN SERVICES

Legislative Report

Opioid Prescribing Improvement Program

Population Health Innovation Team

September 2020

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $4,000.

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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 Minnesota Medicaid and MinnesotaCare enrollees due to the prescribing of opioid analgesics by health care providers. This goal 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 a clinical quality improvement program among Minnesota Health Care Program (MHCP)-enrolled providers whose prescribing behaviors are found to be outside of community standards.

In this annual report we:

- Introduce the Opioid Prescribing Improvement Program;
- Provide a status update on the Opioid Prescribing Work Group;
- Revisit program milestones featured in previous legislative reports;
- Review work completed by the Opioid Prescribing Improvement Program since the publication of the last report to the Legislature;
- Share trend data on opioid prescribing within the MHCP for 2016 through 2019, as well as data that illustrate the variation in opioid prescribing; and
- Provide recommendations for the consideration by the legislature.

II. Legislation

Minnesota Statutes 2017, section 256B.0638, subdivision 7

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

The Opioid Prescribing Improvement Program (OPIP), authorized by Minn. Stat. § 256B.0638 in 2015, is an initiative to reduce opioid dependency and substance use related to the prescribing of opioid analgesics by health care providers. The clinical population is Minnesotans enrolled in Minnesota Health Care Programs (MHCP), also referred to as Medicaid and MinnesotaCare. The OPIP is a unique effort to improve prescriber practice via a community wide improvement process tied to MHCP 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 Legislature charged the OPWG to:

- Develop protocols that address all phases of the opioid prescribing cycle (acute, post-acute and chronic pain);
- Develop sentinel measures based upon evidence-based practices;
- Oversee development of educational resources and messages for providers to use in communicating with patients about pain and the use of opioids to treat pain;
- Recommend quality-improvement measures to assess variation and support improvement in clinical practice; and
- Recommend two sets of thresholds directed at MHCP-enrolled providers with persistently concerning prescribing practices, one threshold that will trigger mandatory quality improvement and the other termination from MHCP.

Opioid dependency and abuse are significant public health concerns both in Minnesota and nationally. The Minnesota Department of Health tracks data related to opioid-related deaths and Figure 1 below references the trends over the past twenty years. Opioid involved deaths are divided into three categories: a) synthetic opioids, such as fentanyl, b) other opioids and methadone—this includes prescriptions opioids-- and c) heroin.

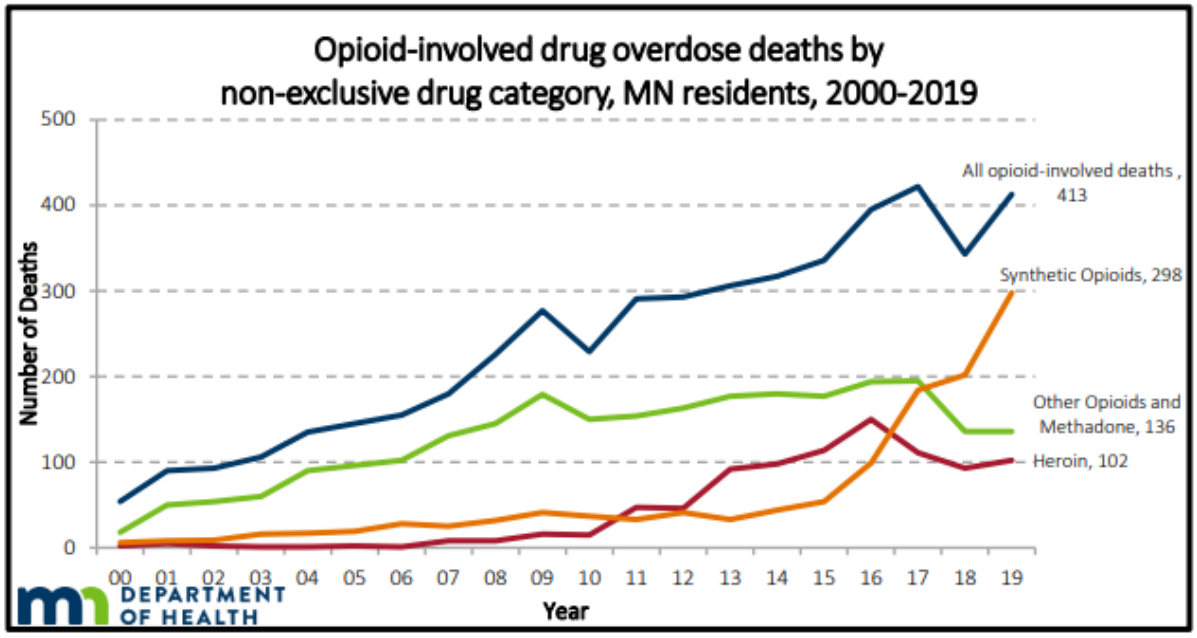
According to preliminary data, opioids were responsible for 413 overdose deaths in 2019, which represents a 25% increase from 331 deaths in 2018. Notably, the 2019 increase in opioid related deaths occurred one year after the first decrease in opioid related deaths since 2010[1].

The 2018 decrease in opioid-related deaths was due, almost exclusively, to an impressive 30% drop in the prescription opioids and methadone category. In 2018 there were 134 overdose deaths from prescription opioids and in 2017 there were 195 deaths. Such progress can be attributed to rigorous and concerted efforts to uphold safe and judicious use of opioid analgesic therapy. OPIP is just one of many initiatives across the state of Minnesota to contribute to this important shift in opioid-related deaths. Unfortunately, despite great strides towards safer use of opioid analgesic therapy, the opioid crisis in Minnesota persists, and the epidemic is now

[1] Minnesota Department of Health. Preliminary 2019 Drug Overdose Deaths Report. July 7, 2020.

driven by heroin and illicitly manufactured fentanyl, fentanyl analogs, and stimulants. Available data indicate that the vast majority of those who use opioids illicitly started by taking opioids prescribed for themselves or others. In addition, although Minnesota health care providers have significantly decreased the amount of opioids prescribed, there remain significant, concerning outliers.

Figure 1: Opioid-involved overdose deaths increased, with a significant increase in synthetic opioid-involved deaths



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

The medical community also recognizes the safeguards intended to curb unsafe opioid prescribing have unintentionally led to new practices that jeopardize patient safety. In June 2019, the authors of the CDC Guideline for Prescribing Opioids for Chronic Pain wrote:

> [U]nfortunately, some policies and practices purportedly derived from (opioid prescribing guidance) have in fact been inconsistent with, and often go beyond, its recommendations … these inconsistencies, which include inflexible application of recommended dosage and duration thresholds and policies that encourage hard limits and abrupt tapering of drug dosages, result in sudden opioid discontinuation or dismissal of patients from a physician's practice. The panel also noted the potential for misapplication of the recommendations to populations outside the scope of the guideline, including patients with cancer-related pain. ... There have also been reports of misapplication of the guideline's dosage thresholds to

opioid agonists for treatment of opioid use disorder. Such actions are likely to result in harm to patients.[2]

In light of changes to opioid analgesia prescribing patterns, concerns about the unintended consequences of current guidelines and the ongoing challenge of preventing opioid use disorder, DHS has worked with the numerous stakeholders on this project over the past year to develop carefully the quality improvement arm of the program in such a way that acknowledges these issues. In addition, the current COVID-19 pandemic and its impact on health care providers and patients may impact how the QI is implemented in year one. DHS is committed to implementing the quality improvement arm of the project in a way that is relevant, collaborative, and upholds patient safety as a shared objective.

[2] Deborah Dowell, M.D., M.P.H., Tamara Haegerich, Ph.D., Roger Chou, M.D. No Shortcuts to Safer Opioid Prescribing. June 13, 2019. N Engl J Med 2019; 380:2285-2287. DOI: 10.1056/NEJMp1904190.

IV. Report Content

A. Opioid Prescribing Work Group Update

The Department of Human Services, in collaboration with the Department of Health, first convened the Opioid Prescribing Work Group (OPWG) in November 2015, with representation as stipulated in the statute. In December 2019, the Commissioner of Human Services authorized a second two-year extension of the OPWG, pursuant to Minnesota Statute § 15.059, Subdivision 6. The purpose of extending the OPWG through December 2021 was to reconvene members in order to accomplish the following tasks: 1) collect input on the specific components for the OPIP quality improvement phase (e.g., use of mental health screening; mandatory checking of the Prescription Monitoring Program); and 2) develop thresholds, based on continued aberrant opioid prescribing behavior, that will guide provider disenrollment from the MHCP.

Following the Commissioner's extension of the OPWG, several changes to the membership roster occurred. Staff filled all appointed seats using the open appointment process under the Secretary of State. The Commissioner approved the addition of two new, non-voting seats to represent individuals who use or have used opioids to manage chronic pain. The intention was that these seats could be designated by the legislature as voting members in a future legislative session. Appendix A is a current list of the OPWG members, including the statutorily set membership categories.

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 consistent. Non-member participants include state government employees, health care providers, community members and pharmaceutical industry representatives. Due to the COVID-19 pandemic, recent OPWG meetings have been hosted using video-conferencing software that allows the public to participate virtually.

B. Opioid Prescribing Improvement Program Updates

Summary of program highlights between 2016 and 2019

The OPIP has achieved many important milestones since beginning work in 2016. Access to previous legislative reports is available at the Minnesota Legislative Reference Library. The summary below briefly describes key OPIP milestones featured in previous legislative reports:

- **April 2018:** The OPWG finalized the Minnesota Opioid Prescribing Guidelines which can be found on the Department of Human Services web site. A summary of the guidelines is provided in Appendix B.
- **July 2018:** DHS and the OPWG developed the OPIP sentinel measures. These seven measures support the quality improvement arm of the program. The measures assess individual prescribing behavior in the acute, post-acute and chronic pain phases. Each measure is associated with an evidence-based risk factor for opioid related harm. An overview of the OPIP sentinel measures and quality improvement thresholds is provided in Appendix C.

- In conjunction with development of the OPIP sentinel measures, the OPWG recommended quality improvement thresholds for five of the seven sentinel measures. Providers whose prescribing rates are over the threshold on any given measure will participate in the QI program.

- **November 2018:** DHS' New Chronic Use measure was reviewed by the National Committee for Quality Assurance (NCQA) and adapted to be a HEDIS 2019 measure, *Risk of Continued Opioid Use*.
- **June 2019:** In collaboration with the medical community, DHS launched a provider awareness campaign named "Flip the Script." The campaign aimed to change the narrative around prescription opioid therapy, pain management and prescription opioid misuse in Minnesota. Flip the Script materials can be found on the OPIP web site and also in Appendix E.
- **Summer 2019:** DHS issued roughly 16,000 individualized opioid prescribing reports to MHCP providers. The purpose of the reports was to establish a baseline for quality improvement efforts that will begin in 2020. A sample report is included in Appendix D. Baseline reports were provided to help providers self-identify potentially problematic prescribing behaviors.

This year's activities and accomplishments

Revision of Taper Guidance

One notable project this year was a complete revision of Section V of the Minnesota Opioid Prescribing Guidelines, Tapering and Discontinuing Opioid Use. The OPWG voted to revise the existing guidance based on several factors. First, there is a growing body of evidence about opioid analgesic tapering in outpatient settings. When the initial opioid guidelines were developed—at both state and federal levels—there were almost no scientific studies of opioid tapering among chronic pain patients. Second, DHS and the OPWG received numerous accounts of too rapid tapers or abrupt discontinuation from the chronic pain patient community. Third, the medical community has repeatedly called for more assistance with tapering opioids – especially in ambulatory care settings.

DHS' official taper revision is in draft form and intended for final approval by the OPWG in autumn 2020. Changes made to DHS' taper guidance reflect growing community support for tapers that are individualized, occur at a much slower rate, and acknowledge that complete cessation of opioids may not be a feasible goal for some patients.

Quality Improvement (QI) Program

The quality improvement program is the final component of the OPIP. Given the potential impact of the QI program, DHS worked collaboratively with stakeholders on development issues during the past year, beginning with the release of the first set of prescribing reports. DHS staff conducted two provider webinars about the prescribing reports, one hosted by the Institute of Clinical Systems Improvement (ICSI), and the other by the Minnesota Hospital Association (MHA). Over one hundred stakeholders attended each webinar. Additionally, DHS staff presented at Project ECHO, an e-learning initiative designed for rural clinics on opioid and controlled substance topics. These community engagements allowed DHS to identify and address two key challenges with the reports, a) many providers did not receive their reports and b) those who received their reports, had

difficulty interpreting the data. Subsequently, DHS reformatted the reports, identified more accurate mailing addresses for providers and issued an updated set of prescriber reports which were mailed in January of 2020.

In addition to individual prescribers, DHS also sought engagement with health systems' leadership. On November 22, 2019, DHS staff convened a meeting of health systems across the state. The Minnesota Hospital Association (MHA) and DHS co-hosted the event with the Institute for Clinical Systems Improvement (ICSI) and the Minnesota Medical Association (MMA). Health systems shared concerns and feedback about OPIP, specifically the report dissemination process, communication from DHS and various aspects related to quality improvement. Notably, health systems urged DHS to develop a quality improvement program with nuance and special attention to those providers who manage patients with complex, chronic pain. Health systems also communicated their desire to act as liaisons between DHS and individual providers. OPIP staff deemed this engagement as key to establishing trust and transparency with Minnesota's medical community.

On December 2, 2019, DHS hosted a listening session for members of the public who have direct and indirect experience with chronic pain. The intended purpose of the listening session was for advocates to offer DHS their personal testimony to help inform future decisions around quality improvement implementation. Over forty individuals shared their personal and deeply harrowing experience with chronic pain. The following is a list of critical themes garnered from public input:

- Chronic opioid analgesic therapy improved quality of life in areas of pain management, overall functioning, personal independence, mental health, as well as social and economic well-being for many people.
- Abrupt, unwanted or forced tapers led to increased pain and suffering and decreased functioning.
- Suicidal ideation was associated with chronic pain.
- Patients felt shamed and stigmatized by medical professionals.
- Chronic pain patients experienced abandonment by their provider or clinic.
- Anxiety and depression are common conditions for those in chronic pain.
- Patients exhausted all other therapeutic interventions, and in most cases, long-term opioids were the only intervention that offered at least some relief from pain.
- Chronic pain patients seek representation at the OPWG.
- Several acupuncturists spoke to the therapeutic effectiveness acupuncture can offer chronic pain patients.

Communication with stakeholders remains an ongoing priority for DHS. In addition to the engagement efforts previously described, staff also maintain an OPIP web page and use GovDelivery, a communication tool that allows stakeholders to subscribe to OPIP-related updates. At last count, there were over 3,000 subscribers to OPIP's distribution list, and the open rates averaged 24% (industry averages are around 15%).

Health equity

In Minnesota, American Indians and African Americans using opioids have significantly worse health outcomes than white, Asian or Hispanic Americans. For example, according to data from the Minnesota Department of Health, American Indians are six times as likely to die from a drug overdose as whites, and African Americans are

twice as likely to die from a drug overdose as white Americans. At the same time, the clinical literature clearly shows that acute pain is under-treated among African Americans, Hispanic Americans and American Indians. These disparities result from deeply embedded systemic racism. This year OPIP is undergoing an equity analysis to ensure its quality improvement framework and implementation does not contribute to unintended harm to American Indian, African American and other historically under-resourced communities and where possible helps address underlying systems and structures that lead to these racial inequities.

COVID-19 pandemic

The COVID-19 pandemic has placed exorbitant stress on the healthcare system. Hospitals, clinics, health care professionals, patients and their caregivers face a novel set of challenges. Healthcare professionals now work in environments that are more dangerous and chronically stressful than ever before. Likewise, patients with conditions such as pain, anxiety, depression and substance use disorder may experience exacerbation of symptoms as a result of stay at home orders and social distancing. Chronic pain patients may also be more vulnerable due to interrupted access to multi-modal treatments such as acupuncture, cognitive behavioral therapy and physical therapy. DHS staff continue to consult with the OPWG, clinical experts and the community to determine an appropriate implementation of state-mandated quality improvement. Striking a balance between the different, but important, priorities of two public health crises is an important challenge facing OPIP in the coming months.

Quality improvement partnerships

In 2020 DHS leveraged federal State Opioid Response (SOR) dollars to contract with the Institute for Clinical Systems Improvement (ICSI) and the Minnesota Hospital Association (MHA), both experts in clinical quality improvement. ICSI and MHA each developed resources that support the OPIP quality improvement program, and align with their organizational approach to working with the health care community. Both entities worked closely with their own advisory bodies of clinicians, bringing even more direct clinical input into the QI work. The ICSI and MHA resources will be available in fall 2020.

Legislative changes to continuing education requirements

Staff also dedicated time to new legislation, Minnesota Statutes 2017, section 214.12, subdivision 6, section (a), which requires Minnesota licensees with the authority to prescribe controlled substances to obtain at least two hours of continuing education credit (CME) on best practices in prescribing opioids and controlled substances. While participants of OPIP are exempt from this requirement, the legislation generated a substantial amount of unanticipated work for DHS staff who responded to thousands of providers inquiring into their OPIP status. DHS has worked with the licensing boards to help clarify information for providers.

C. Opioid Prescribing Data

Decreases observed from 2016-2019

DHS staff regularly analyze prescribing data for MHCP-enrolled providers in order to support the OPIP work. There are positive trends across all three pain stages. Appendix F offers an overview of DHS prescribing data. Notable highlights and trends include:

- Overall opioid prescribing: There was a 17% decrease in the overall number of opioid prescriptions in the MHCP from 2018 to 2019. In 2019, there were 565,877 opioid prescriptions filled for MHCP enrollees (excluding patients with cancer and patients receiving hospice services). This number decreased by 50% since 2016.

- New opioid prescriptions for acute pain: There was an 11% decrease in the total number of index opioid prescriptions filled by MHCP enrollees from 2018 to 2019. An index opioid prescription is the first opioid prescription filled by an enrollee when the enrollee has not had any active opioid prescriptions for the previous 90 days. In 2019, there were 117,877 index opioid prescriptions filled. This number has decreased by 35% since 2016.

- Chronic Opioid Analgesic Therapy (COAT): In 2019, there were 16,252 COAT recipients, marking a 26% decrease from 2018. An individual is considered to receive chronic opioid therapy if he or she had a continuous supply of opioids for 60 days in the calendar year. The number and rate of enrollees who became *new* chronic users decreased nearly 16% from 2018 to 2019. Figure 1 indicates the eight-year trend for new chronic users in the MHCP population.

- New Chronic Use: There was a 35% decrease in the number of MHCP enrollees who went from being opioid naïve to having at least 45 days of opioid use in the calendar year (New Chronic Users). See Figure 2. Although the New Chronic Use measure is not an OPIP sentinel measure, DHS uses the measure to monitor progress on preventing new chronic use by reducing the amount of opioids prescribed for acute pain. The reduction in new chronic users is supported by multiple interventions across DHS, including pharmacy limits on new opioid prescriptions, a Managed Care Organization (MCO) Performance Improvement Program (PIP) on preventing new chronic users among health plan members, and the OPIP.

Figure 2: Annual number of new chronic opioid users in the Minnesota Health Care Programs enrollee population, 2012-2019

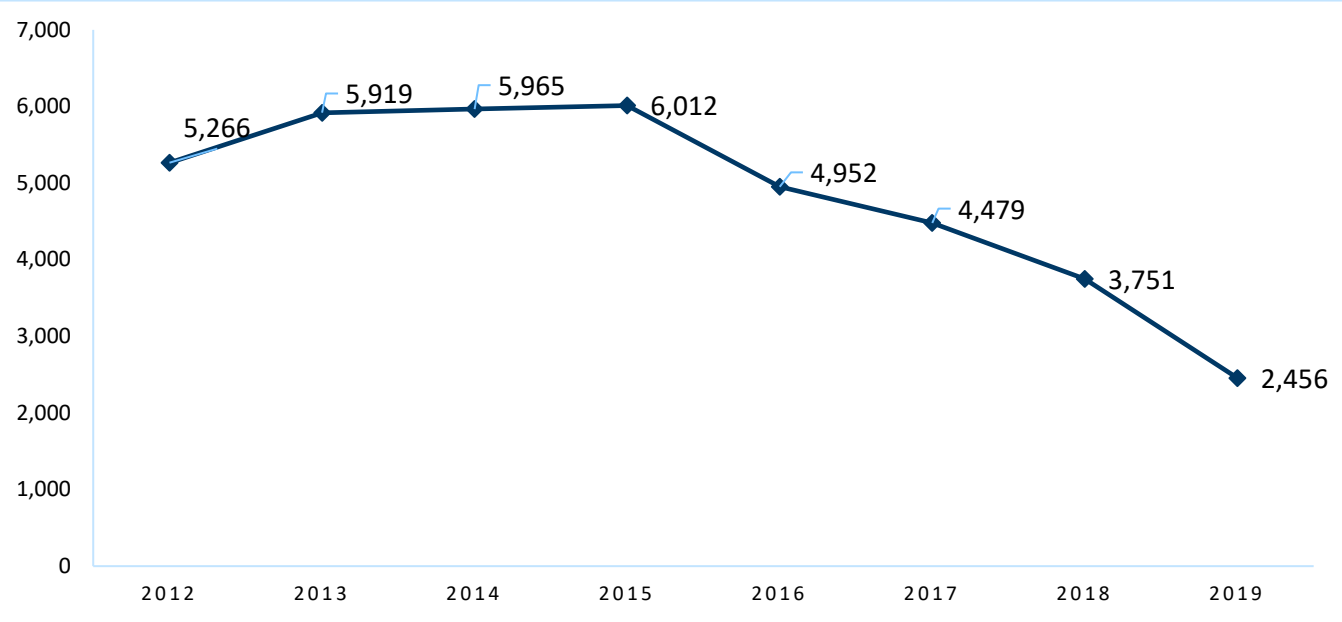


Figure 2 shows the number of New Chronic Users in the MHCP population from 2012 to 2019. New Chronic Use is defined as the number of enrollees who were previously opioid naïve (no opioid prescription in a 90-day look back period) who then receive 45 days or more of opioids in the 90 days following the index opioid prescription.

Variation among health care providers

Variation in opioid prescribing can indicate problematic prescribing behaviors. When providers are grouped by specialty with their clinical peers, variation should be minimal unless explained by factors such as distinct differences in patient populations and severity of disease. DHS and the OPWG identified significant variation in opioid prescribing practices among specialties in 2016. These data were used to support development of the sentinel measures and quality improvement program.

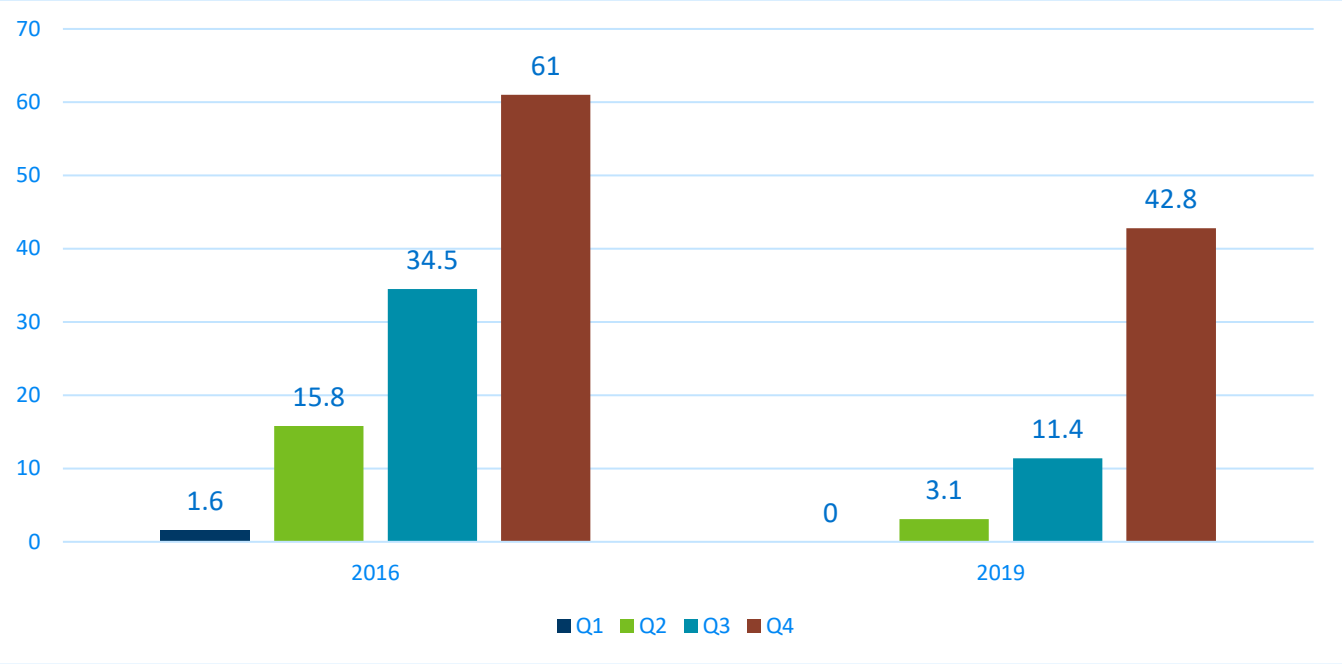
DHS continues to analyze the variation in prescribing behavior across the seven OPIP sentinel measures in order to gauge progress within the project. The goal is not to eliminate variation entirely, given that appropriate patient-centered care requires some level of variability. However, successful implementation of evidence-based prescribing guidance should result in a reduction in variation by reducing the number of outliers in any given specialty.

Comparisons of 2016 and 2019 opioid prescribing data within the MHCP indicates that variation within specialties is decreasing, yet there remain a population of providers who consistently prescribe above the community standards. Figure 3 below illustrates the changes in data using Emergency Medicine as an example. The OPIP Measure 2 analyzes how often a prescriber writes a prescription over the recommended dose to someone who was previously not on opioid therapy. State and federal guidance recommends that initial opioid

prescriptions for acute pain be limited to 100 morphine milligram equivalence (MME). MME is a term used to describe the dose of an opioid.

Emergency medicine providers are uniquely suited for analyses of variation because their practice does not significantly differ based on their geographic location, health system characteristics, etc. In 2016, analysis of opioid prescribing rates among emergency medicine providers found that the average rate of prescribing over the recommended dose among the quartile of prescribers with the highest rates (Q4) was 38 times higher than the prescribing rate of providers in the quartile with the lowest rates (Q1). In addition, differences in the average prescribing rates in each quartile were essentially equally distributed. In 2019, the data indicates a significant reduction in the variation between the first three quartiles. However, the average prescribing rate in the highest quartile remains significantly higher than the others. In 2019, the difference between the average rate in the highest quartile was over 42 times higher than the rate of the lowest quartile.

Figure 3: The rate of prescribing above the recommended dose (100 MME for the initial prescription) among Emergency Medicine providers, 2016 and 2019 (OPIP Measure 2)



How to interpret the charts: There were 910 Emergency Medicine providers, for example, who prescribed an index opioid prescription to at least one MHCP enrollee in 2016. Those 910 providers were divided into four equal quartiles (Q1-Q4) based on the rate at which they prescribed an index opioid greater than 100 MME. Thus, the numbers displayed above each bar indicate the average rate emergency medicine providers exceed 100 MME within each quartile. Providers in Q1 are those with the lowest prescribing rates (1.6%) and providers in Q4 are those with the highest prescribing rates (61%).

The comparative data among Emergency Medicine providers indicates reduced variation among 75 percent of the providers in that specialty, while a smaller population continues exceed the recommended dose in nearly half of the opioid prescriptions they write. The overall decline in prescribing rates is important, but the data also suggests that there remain providers in the community who are either prescribing too frequently and or with initial doses that exceed the recommendations. The OPIP quality improvement program provides the state with an opportunity to engaged with this provider population.

V. Report Recommendations

In the upcoming year, the OPIP anticipates reductions in opioid analgesic therapy across all seven sentinel measures, as well as decreases in specialty variation and in overdose deaths caused by prescription opioids. In order to accomplish these outcomes, DHS recommends the OPIP continue its intended course which is to complete the following tasks a) issue 2020 opioid prescribing reports, b) implement the quality improvement program, c) establish the disenrollment standards for the quality improvement program, and d) assess and respond to new or evolving programmatic issues. All tasks will incorporate equity analysis and design with an equity lens.

DHS also recommends two overall improvements to the program that would require legislative action:

a) Change the non-voting status to voting status for the two new OPWG seats for individuals who use or have used opioids to manage chronic pain; and
b) Allow DHS to distribute prescribing reports to all provider groups with which individual prescribers are affiliated.

VI. Appendices

Appendix A. Opioid Prescribing Work Group Members

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

- Nathan Chomilo, MD, Minnesota Department of Human Services (Minnesota Health Care Programs medical director; nonvoting)
- Kurtis Couch, Waterville, (Public member who uses or who has used opioid therapy to manage chronic pain)
- Julie L. Cunningham, PharmD, BCPP, Mayo Clinic Health System (non physician health care professional who treats pain)
- Sen. Chris Eaton, RN, Minnesota State Senate (consumer representative)
- Tiffany Elton, PharmD, NCPS, Consultant (pharmacist)
- Dana Farley, MS, Minnesota Department of Health (nonvoting)
- Rebekah Forrest, RN, CNP, NorthPoint Community Clinic (nurse practitioner)
- Ifeyinwa Nneka Igwe, MD, Essentia Health (physician)
- Bradley Johnson, MD, South Country Health Alliance (health plan medical director)
- Chris Johnson, MD, Allina Health (Health Services Advisory Council member)
- Ernest Lampe, MD, Minnesota Department of Labor and Industry (DLI medical consultant; nonvoting)
- Matthew Lewis, MD (not practicing), Winona (consumer representative)
- Adam Nelson, PharmD, CSP, UCare (health plan pharmacy director)
- Murray McAllister, PsyD, LP, Courage Kenny Rehabilitation Institute (non physician health care professional who treats pain)
- Richard Nadeau, DDS, MPH, University of Minnesota School of Dentistry (dentist)
- Chad Hope, PharmD, Department of Human Services (DHS pharmacy unit; nonvoting)
- Charles Reznikoff, MD, Hennepin County Medical Center (mental health professional)
- Saudade SammuelSon, Richfield, (Public member who uses or who has used opioid therapy to manage chronic pain)
- Detective Charles Strack, Little Falls Police Department (law enforcement)
- Lindsey Thomas, MD, Midwest Medical Examiner's Office, retired (medical examiner)

Appendix B. Minnesota Opioid Prescribing Guidelines

The complete Minnesota Opioid Prescribing Guidelines are available on the DHS web site. A summary of the prescribing guidelines reflect three broad values described below. Definitions of clinical terminology is also provided.

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

    - *Avoid prescribing more than 100 morphine milligram equivalents (MME) of low-dose, short-acting opioids.*
    - *Limit the initial prescription for acute pain following extensive surgical procedures or major traumatic injury to no more than 200 MME, unless circumstance clearly warrant additional opioid therapy.*

2. **Monitor the patient closely during the post-acute pain period.** The post-acute pain period is a critical time to prevent chronic opioid use. Increase assessment of the biopsychosocial factors associated with opioid-related harm and chronic opioid use during this period.

    - *Avoid prescribing in excess of 700 MME (cumulatively) in order to reduce the risk of chronic opioid use and other opioid-related harms.*

3. **Avoid initiating chronic opioid therapy and carefully manage any patient who remains on opioid medication.** The evidence to support long-term opioid therapy for chronic pain is insufficient but the evidence of harm is clear.

    - *Prescribe opioids at the lowest dose, with no more than 50 MME/day. Avoid increasing daily dosage to 90 MME/day or above.*
    - *Actively work to lower risks when prescribing long-term opioids and throughout the therapy. Strategies and frequency should be commensurate with risk factors.*
    - *Avoid prescribing concurrent prescriptions of opioids and benzodiazepines or other sedative-hypnotic medications.*

Terms	Definition
Opioid Formulations (Acute Pain)	Only oral tablet formulations are used for the index opioid prescription and initial opioid prescribing episode measures.
Opioid Formulations (Chronic Pain)	All formulations are included in the chronic opioid prescribing measure. Excluded drugs are buprenorphine-naloxone buccal films, fentanyl transdermal device, injectables and opioid cold and cough products.

Terms	Definition
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 equianalgesic of a specific dose and formulation of opioids to parenteral morphine. Standard conversion ratios are used to calculate each opioid's equianalgesic dose.
Days' supply	The total days' supply is the sum of the days' supply from all opioid prescriptions prescribed during the measurement period. If two medications have different service dates, but the days' supply overlaps, both days' supply are included in the total.
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.
Chronic opioid prescriber	A health care provider who prescribes at least 60 consecutive days' supply of opioids to an individual during the measurement period.
Concomitant COAT and benzodiazepine prescriptions	A ≥ 60 consecutive days' supply of opioids and a benzodiazepine prescription which has > 7 days' supply of overlap with the COAT during the measurement year
Elevated dose COAT	A ≥ 60 consecutive days' supply of opioids and the daily dose is ≥ 50 MME. A provider who prescribes ≥ 50 MME/day at any point during a patient's COAT is counted as having prescribed an elevated dose.
High dose COAT	A ≥ 60 consecutive days' supply of opioids and the daily dose is ≥ 90 MME. A provider who prescribes ≥ 90 MME/day at any point during a patient's COAT is counted as having prescribed a high dose.

Appendix C. Sentinel Measure Overview

The sentinel measures support the quality improvement arm of the program. DHS and the Opioid Prescribing Work Group developed the measures by analyzing Minnesota Medicaid and MinnesotaCare prescription data and considering national measures across acute, post-acute and chronic pain stages.

Percent of enrollees prescribed an index opioid prescription	Distinct number of patients with one or more index opioid prescriptions prescribed in the measurement period	Distinct number of patients seen by the provider in the measurement period	Prescribing rate is > 8% (non-surgical specialties only)
Percent of index opioid prescriptions exceeding the recommended dose	Number of index opioid prescriptions exceeding 100 MME (medical specialty) or 200 MME (surgical specialty) prescribed in the measurement period	Number of index opioid prescriptions prescribed in the measurement period.	Prescribing rate is > 50%
Percent of prescriptions exceeding 700 cumulative MME in the post-acute pain phase	Number of prescriptions that 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 in the measurement period	Prescribing rate is > 15%
Percent of patients with chronic opioid analgesic therapy (COAT)	Number of patients with a prescription during a COAT period (≥ 60 consecutive days' supply of opioids) during the measurement period.*	Number of patients with at least one opioid prescription prescribed during the measurement period.	No quality improvement threshold
Percent of COAT enrollees exceeding 90 MME/day (High-dose COAT)	Number of patients prescribed COAT of > 90 MME/day in the measurement period.**	Number of patients with a prescription during a COAT period during the measurement period.*	Prescribing rate is > 10%
Percent of enrollees receiving elevated dose COAT who received a concomitant benzodiazepine	Number of patients prescribed COAT of > 50 MME/day and an overlapping benzodiazepine prescription > 7 days in the measurement period.**	Number of patients with a prescription during a COAT period during the measurement period.*	Prescribing rate is > 10%
Percent of COAT patients receiving opioids from multiple prescribers	Number of patients on COAT who received opioids from 2+ additional providers while on COAT during the measurement period.	Number of patients with a prescription during a COAT period during the measurement period.*	No quality improvement threshold

Appendix D. Sample Prescriber Report

DEPARTMENT OF HUMAN SERVICES

Your 2019 Opioid Prescribing Report

This report compares your opioid prescribing to your specialty peers. It references prescriptions written to Minnesota Medicaid and MinnesotaCare members between July 2018 and June 2019. This report includes 7 measures associated with 3 phases of the prescribing cycle: index opioid prescriptions (acute); opioids prescribed up to 45 days after an index prescription (post-acute), and chronic opioid analgesic therapy.

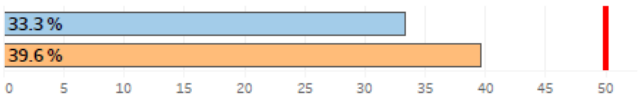
Your Specialty: Family Medicine NPI: 9999999999

FAKE PRESCRIBER
MN DEPT HUMAN SERVICES
540 CEDAR ST
ST PAUL, MN 55101

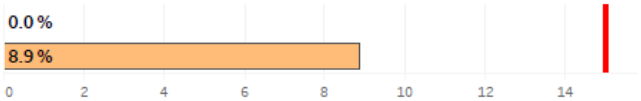
Legend
Your Percent (%) 5.0
Average % of Your Specialty 7.5
Quality Improvement Threshold: Red Line
Denominator = (Denominator of measure)

Measure 1 (Acute)
Percent (%) of enrollees prescribed an index opioid prescription
Numerator = 6 / Denominator = 281

Measure 2 (Acute)
Percent (%) of index opioid prescriptions exceeding the recommended dose
Numerator = 2 / Denominator = 6



Measure 3 (Post-Acute)
Percent (%) of prescriptions exceeding 700 cumulative MME in the 45 days following an index opioid prescription
Numerator = 0 / Denominator = 9



Measure 4 (Chronic)
Number of enrollees receiving opioids who are on Chronic Opioid Analgesic Therapy (COAT)
1 / 11 (No Quality Improvement threshold attached to this measure)

Measure 5 (Chronic)
Percent (%) of COAT enrollees exceeding 90 MME/day (High-dose COAT)
Numerator = 0 / Denominator = 1

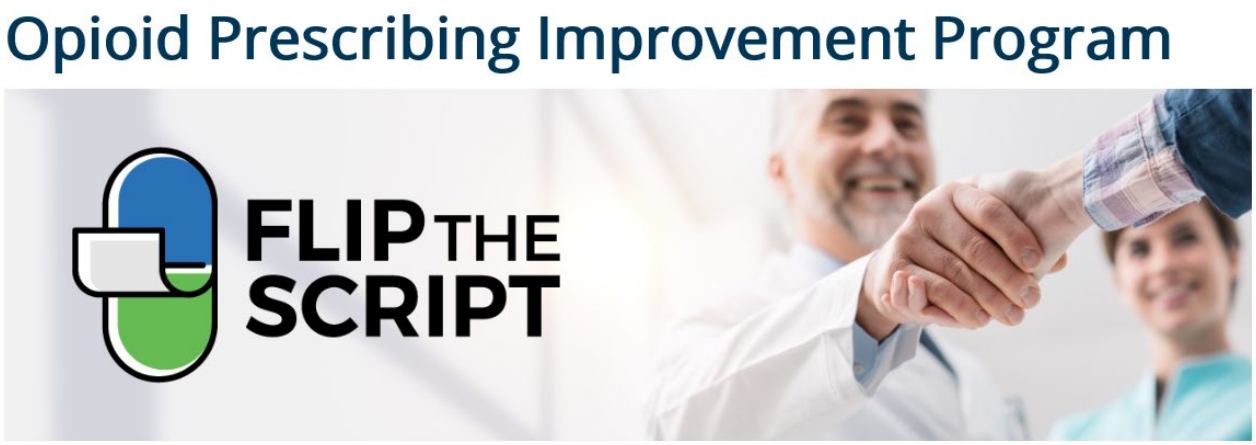
Measure 6 (Chronic)
Percent (%) of enrollees receiving COAT who received a concomitant benzodiazepine
Numerator = 0 / Denominator = 1

Measure 7 (Chronic)
Number of enrollees prescribed COAT who received an opioid prescription from two or more additional providers
0 / 1 (No Quality Improvement threshold attached to this measure)

Comprehensive information is available at: https://mn.gov/dhs/opip

Comments or questions about your report can be submitted here: https://mn.gov/dhs/opip/quality-improvement-program/ or by e-mailing dhs.opioid@state.mn.us

Appendix E. “Flip the Script” Provider Materials



Many provider resources can be accessed via the OPIP web site including the following discussion guides:

- Discussion guide for health care providers who prescribe opioids (PDF)
- Discussion guide for health care providers who do not prescribe opioids (PDF)
- Difficult conversations (PDF): suggestions for responses to common questions about opioid use and pain management (PDF)

Appendix F. Minnesota Health Care Programs Opioid Prescribing Trends, 2016-2019

Table 1 represents data trends for opioid prescribing in the acute, post-acute, and chronic pain phases for MHCP enrollees between 2016 and 2019.

	2016	2017	2018	2019
General Data				
MHCP Enrollees	1,224,566	1,218,898	1,232,690	1,191,442
Opioid Prescriptions	788,383	684,334	565,877	393,495
Enrollees receiving opioids	192,785	172,284	151,204	110,358
Opioid Prescribers	16,975	16,589	16,397	15,820
Acute Prescribing				
Index Opioids	152,132	132,664	117,877	98,126
Index Opioids > 100 MME	78,354	64,943	51,910	33,810
% Index Opioids > 100 MME	51.50%	49.00%	44.00%	34.46%
Opioid Rx in initial prescribing episode	224,441	194,257	169,537	141,294
Post-Acute Prescribing				
Opioid Rx in initial episode > 700 MME	26,055	21,428	16,824	9,350
% opioid Rx in initial episode > 700 MME	11.60%	11.00%	9.90%	6.62%
Chronic Prescribing				
COAT Recipients	21,667	19,001	16,252	13,429
High-dose COAT Recipients	3,020	2,461	1,812	1,257
% high-dose COAT recipients	13.90%	13.00%	11.10%	9.36%
COAT recipients with concomitant benzodiazepines	2,541	1,978	1,446	968
% COAT recipients with concomitant benzodiazepines	11.70%	10.40%	8.90%	7.21%
COAT recipients with 2 additional prescribers	2,194	2,481	1,914	1,582
% COAT recipients with 2 additional prescribers	10.10%	13.10%	11.80%	11.78%