Overview of the Minnesota Opioid Prescribing Guidelines

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Learning Objectives

- Describe the main prescribing points of the acute, post-acute and chronic pain guidelines
- Understand resources used in the guideline development
- Review measures and threshold for prescribing metrics

Disclaimer

- The presenter has no financial conflicts of interest to declare.
- All sources where available have been credited.
- The presentation includes data on opioid prescribing within the Minnesota Health Care Programs. The data analysis was developed to guide discussion among the Opioid Prescribing Work Group members.
- These slides have been developed from the Minnesota Department of Human Services in collaboration with the Opioid Workgroup.

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)

- 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)

Where can MN stake a stand? New chronic use

- Goal: Develop a clinically useful outcome measure that would support quality improvement efforts to prevent chronic opioid use
- Definition: 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
- **Over 5,000 individuals per year**

The new 5,000 chronic users

- Demographically:
  - On average older than other new opioid users
  - More likely to be female
  - More likely to be white, although NA disproportionately represented
- Diagnostically:
  - Only 15% had cancer diagnosis
  - **Over 80% have mental health condition, substance use, or both**
- Geographically: about 50% in the 7-county metro
- Nearly 75% of new chronic users received initial prescription in an outpatient setting

Post-acute pain interval: Up to 45 days following an acute event

- Critical time period to:
  - Assess patients for the presence of psychosocial factors that may predict transition to chronic opioid use
  - Cease opioid therapy for acute pain management
- Analysis of DHS claims data found that:
  - Among enrollees with ≥ 45 days supply of opioids over a 90 day period → 52% received at least 200 days of opioid therapy in the measurement year
  - Among enrollees with ≥ 60 days supply of opioids over a 90 day period → 58% received at least 200 days of opioid therapy in the measurement year

Addressing chronic opioid use and opioid-related morbidity and mortality

- Prevention
  - Acute and post-acute pain
  - In emergency departments and clinics
- Chronic pain management
  - Optimal dosing, access to non-opioid therapies, opportunities to taper
- Treatment for addiction
  - Expended MAT/OBOT

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

MN Opioid Prescribing Guidelines: Process

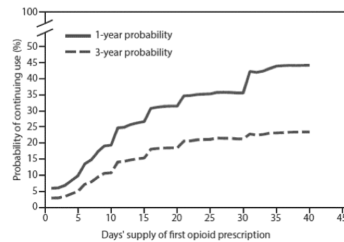
- Workgroup used the following as starting points:
  - Institute for Clinical Systems Improvement Pain Health Care Guideline (2016)
  - CDC Guideline for Opioid Prescribing for Chronic Pain (2016)
  - VA/DoD Pain Clinical Practice Guideline (2016)
  - Washington State Agency Medical Directors Group (2015)
- Reviewed other current literature on opioid prescribing
- Consensus based discussion of existing recommendations and evidence, expertise, patient safety, ease or burden of implementation
- Recommendations available: http://gov.state.mn/opwg

Key principles for prescribing recommendations: Prevention

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.

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

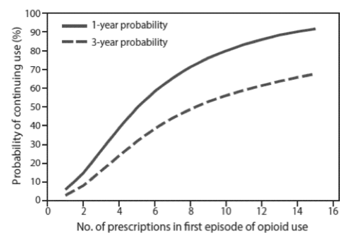
FIGURE 1. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of days' supply* of the first opioid prescription — United States, 2006–2015



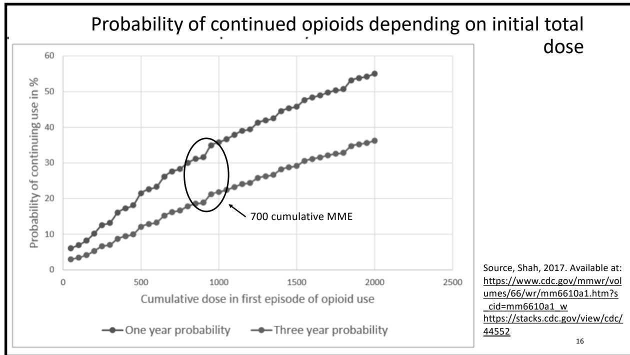
Source: Shah A, Hayes CJ, Martin BC. Characteristics of initial opioid prescription episodes and likelihood of long-term opioid use – United States, 2006-2015. MMWR Morb Mortal Wkly Rep 2017;66(1):265-269. Available at: https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm

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



Morphine Milligram Equivalence (MME)

- Total MME: The total MME of a single prescription
  - 15 tablets of Hydrocodone 5 mg
  - (Hydrocodone 5 mg)*(15 tablets)*(Conversion factor: 1) = 75 MME
- **Cumulative morphine milligram equivalence:** MME exposure over a period of time or treatment interval
  - Patient's first Rx is 30 tablets of Oxycodone HCL 5 mg = 225 MME (total)
  - Patient's second Rx is 10 tablets of Oxycodone HCL 5 mg = 75 MME (total)
  - Cumulative MME exposure: 225 MME + 75 MME = **300 cumulative MME**

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New persistent opioid use after minor and major surgical procedures in US adults. Brummett et al. *JAMA Surg* June 2017

Key Points

Question: What is the incidence of new persistent opioid use after surgery?

Findings**:** In this population-based study of 36,177 surgical patients, **the incidence of new persistent opioid use after surgical procedures was 5.9% to 6.5% and did not differ between major and minor surgical procedures.**

Meaning**:** New persistent opioid use is more common than previously reported and can be considered one of the most common complications after elective surgery.

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Wide variation and overprescription of opioids after elective surgery. Thiels et al. *Ann Surg* October 2017

1. Patients given > 300 MME post-operative
2. Wide variability between procedures, providers, and medical centers
3. Increased initial quantity did not decrease chance of refills

Key Clinical Points from the Opioid Prescribing Recommendations: Acute Pain Interval

- Avoid prescribing more than 100 MME of low-dose, short-acting opioids. Limit the entire prescription to 100 morphine milligram equivalents (MME) (not 100 MME per day).
- Prescribe no more opioids than will be needed for initial tissue recovery following more extensive surgical procedures and traumatic injury. Limit the initial acute prescription to no more than seven days or up to 200 MME, unless circumstances clearly warrant additional opioid therapy. Certain surgical procedures may require additional pain management (e.g., total joint replacement, major spine surgery).
- Check the Prescription Monitoring Program (PMP) to review the patient's prescribing history whenever prescribing an opioid for acute pain.

Key Clinical Points from the Opioid Prescribing Recommendations: Post-Acute Pain Interval

- Assess and document risk factors for opioid-related harm and chronic use during the post-acute pain phase, including depression, anxiety, substance abuse, fear avoidance, and pain catastrophizing. Refer to the Prescribing and Assessment Guide for the recommended risk assessments and screenings prior to prescribing additional opioids.
- 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. 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.
- Develop a referral network for mental health, substance use disorder, pain education, and pain medicine.

Key principles, continued: 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** for new chronic pain patients, and **carefully manage** those who remain on medication.

Key Clinical Points from the Opioid Prescribing Guidelines: Chronic Pain

- Prescribe opioids at the lowest dose, with no more than 50 MME/day. Avoid increasing daily dosage to ≥ 90 MME/day.
  - Clinicians who decide to increase daily dose to ≥ 90 MME/day must carefully document that the risk and benefits were weighted, and benefits warrant the risk.
- 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.

Patient outcomes in dose reduction or discontinuation of long-term opioid therapy: a systematic review. Frank et al. *Ann Intern Med* Aug 2017

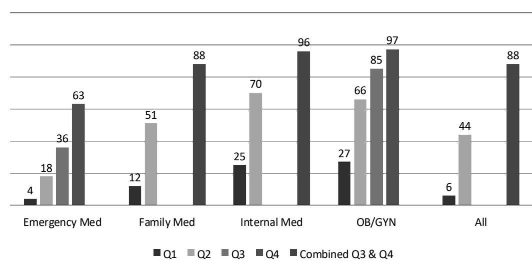
- Review of 67 studies examining 8 intervention categories
- Many studies reported dose reduction, but rates of opioid discontinuation ranged widely across interventions and the overall quality of evidence was very low
- Among 40 studies examining patients outcomes after dose reduction (very low overall quality of evidence), improvement was reported in pain severity, function, and quality of life

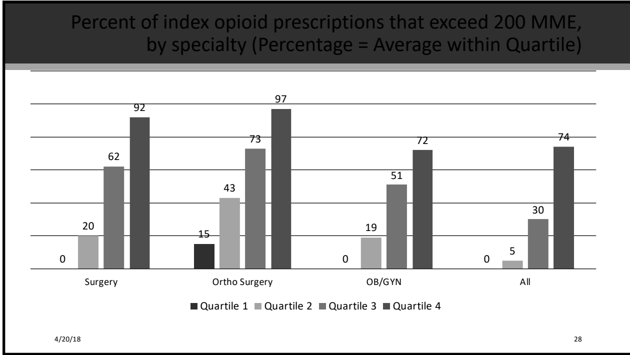
Key Clinical Points from the Opioid Prescribing Guidelines: Taper or discontinue opioid therapy

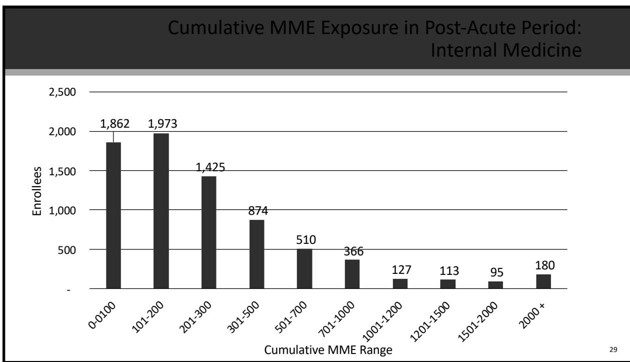
- Address tapering and discontinuing opioid therapy in advance of initiating therapy, and with every dose increase. Discuss with the patient tapering to a reduced dose or to discontinuation at least every 3 months.

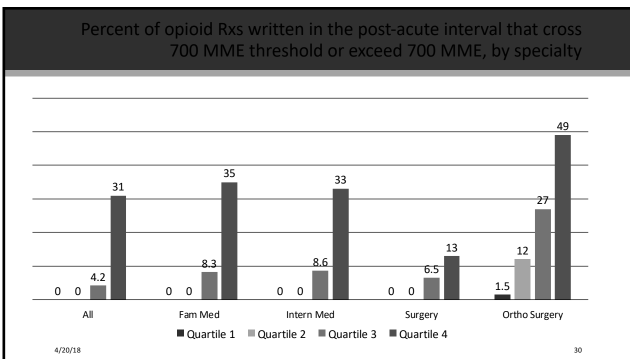
Opioid prescribing data within the Minnesota Health Care Programs

Percent of index opioid prescriptions that exceed 100 MME, by specialty (Percentage = Average within Quartile)




Percent of index opioid prescriptions that exceed 200 MME, by specialty (Percentage = Average within Quartile)
0
20
62
92
15
43
73
97
0
19
51
72
0
5
30
74
Surgery
Ortho Surgery
OB/GYN
All
Quartile 1
Quartile 2
Quartile 3
Quartile 4
4/20/18
28


Cumulative MME Exposure in Post-Acute Period: Internal Medicine
2,500
2,000
1,500
1,000
500
-
Enrollees
1,862
1,973
1,425
874
510
366
127
113
95
180
0-0100
101-200
201-300
301-500
501-700
701-1000
1001-1200
1201-1500
1501-2000
2000 +
Cumulative MME Range
29


Percent of opioid Rxs written in the post-acute interval that cross 700 MME threshold or exceed 700 MME, by specialty
0
0
4.2
31
0
0
8.3
35
0
0
8.6
33
0
0
6.5
13
1.5
12
27
49
All
Fam Med
Intern Med
Surgery
Ortho Surgery
Quartile 1
Quartile 2
Quartile 3
Quartile 4
4/20/18
30

MHCP enrolled providers: Quality improvement review

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

OPIP: Opioid prescribing sentinel measures (proposed)

1. Index opioid prescribing rate (frequency)
2. Rate of prescribing index opioid prescriptions over 100 MME or 200 MME (higher MME for surgical specialties)
3. Percent of opioid prescriptions written in the post-acute interval that cross the 700 MME threshold or exceed 700 MME
4. Number of enrollees prescribed chronic opioid therapy
5. Percent of enrollees prescribed high-dose (>90 MME/day) chronic opioid therapy
6. Number of enrollees receiving concomitant opioids and sedatives
7. Number of enrollees on chronic opioid therapy receiving opioids from 4+ prescribers

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

DEPARTMENT OF HUMAN SERVICES

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

You	9
Family Practice	5
All providers	6

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

You	70
Family Practice	57
All providers	45

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

You	20
Primary Care	9
All providers	9

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

Prescriber education campaign

- DHS is currently working with Weber Shandwick to develop an education campaign targeted to prescribers
- 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 in early Winter 2018

Summary

- Prevent progression to chronic opioid use
  - Appropriate opioid prescribing for acute and post-acute pain, when indicated
  - In emergency departments and clinics
- Maximize patient safety of chronic opioid use continues
  - Optimal dosing, access to non-opioid therapies, opportunities to taper
- Treatment for addiction
  - Expended MAT/OBOT

QUESTIONS?