Opioid “Report Card”

opioid oversight from MN Dept of Health

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Disclosures

• I have no relevant financial disclosures
• I am not discussing off label use of medications
How often do you prescribe opioids for acute pain?
When you do prescribe for acute pain, do you prescribe high dose opioids?
How often, under your care, do opioids for acute pain become chronic daily opioid use?
For what percentage of your patients do you prescribe daily opioids for chronic pain?
What percentage of your patients on daily opioids for chronic pain are on high dose opioids?
What percentage of your patients on chronic opioids for chronic pain are also on benzos?
What percentage of your patients on daily opioids for chronic pain are “doctor shopping”?
How does your opioid prescribing compare to your colleagues?
Is anyone watching your opioid RXs?
Is anyone giving you feedback?
Is anyone watching your opioid RXs?
Is anyone giving you feedback?

Should anyone be?
Opioid measures to be reported on annually to providers of MN Medicaid recipients

- Acute prescribing rates
- Acute prescribing doses
- Stopping acute opioids early
- Chronic prescribing rates
- Mixing chronic opioids and benzos
- High dose chronic prescribing
- Prescribing to “doctor shoppers”

https://edocs.dhs.state.mn.us/lfs/server/Public/DHS-7763-ENG
Example of an Opioid Report

First report early 2019
MN OPIP law passed 2015

256B.0638 OPIOID PRESCRIBING IMPROVEMENT PROGRAM.

Subdivision 1. Program established. The commissioner of human services, in consultation with the commissioner of health, shall coordinate and implement an opioid prescribing improvement program to reduce opioid dependency and substance use by Minnesotans due to the prescribing of opioid analgesics by health care providers.

Subd. 2. Definitions. (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Commissioner" means the commissioner of human services.

(c) "Commissioners" means the commissioner of human services and the commissioner of health.

(d) "DEA" means the United States Drug Enforcement Administration.

(e) "Minnesota health care program" means a public health care program administered by the commissioner of human services under this chapter and chapter 256L, and the Minnesota restricted recipient program.

(f) "Opioid disenrollment standards" means parameters of opioid prescribing practices that fall outside community standard thresholds for prescribing to such a degree that a provider must be disenrolled as a medical assistance provider.

(g) "Opioid prescriber" means a licensed health care provider who prescribes opioids to medical assistance and MinnesotaCare enrollees under the fee-for-service system or under a managed care or county-based purchasing plan.

(h) "Opioid quality improvement standard thresholds" means parameters of opioid prescribing practices that fall outside community standard thresholds for prescribing to such a degree that quality improvement is required.

(i) "Program" means the statewide opioid prescribing improvement program established under this section.

(j) "Provider group" means a clinic, hospital, or primary or specialty practice group that employs, contracts with, or is affiliated with an opioid prescriber. Provider group does not include a professional association supported by dues-paying members.

(k) "Sentinel measures" means measures of opioid use that identify variations in prescribing practices during the prescribing intervals.

Subd. 3. Opioid prescribing work group. (a) The commissioner of human services, in consultation with the commissioner of health, shall appoint the following voting members to an opioid prescribing work group:

(1) two consumer members who have been impacted by an opioid abuse disorder or opioid dependence disorder, either personally or with family members;

(2) one member who is a licensed physician actively practicing in Minnesota and registered as a practitioner with the DEA;

(3) one member who is a licensed pharmacist actively practicing in Minnesota and registered as a practitioner with the DEA;

(4) one member who is a licensed nurse practitioner actively practicing in Minnesota and registered as a practitioner with the DEA;

(5) one member who is a licensed dentist actively practicing in Minnesota and registered as a practitioner with the DEA;

(6) two members who are nonphysician licensed health care professionals actively engaged in the practice of their profession in Minnesota, and their practice includes treating patients with chemical dependency or substance abuse;

(7) one member who is a mental health professional who is licensed or registered in a mental health profession, who is actively engaged in the practice of that profession in Minnesota, and whose practice includes treating patients with chemical dependency or substance abuse;

(8) one member who is a medical examiner for a Minnesota county;

(9) one member of the Health Services Policy Committee established under section 256B.0625, subdivisions 3c to 5e;

(10) one member who is a medical director of a health plan company doing business in Minnesota;

(11) one member who is a pharmacy director of a health plan company doing business in Minnesota; and

(12) one member representing Minnesota law enforcement.

(b) In addition, the work group shall include the following nonvoting members:

(1) the medical director for the medical assistance program;

(2) a member representing the Department of Human Services pharmacy unit; and

(3) the medical director for the Department of Labor and Industry.

(c) An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each voting member in attendance.
OPWG legislative mandate

• Generate recommendations for opioid prescribing based on current literature
• Analyze 2016 MN Medicaid opioid prescribing data
• Develop sentinel measures for opioids prescribing
• Provide feedback on sentinel measures to Minnesota providers
• Quality improvement for outlying prescribers
• Educational campaign
The OPIP/OPWG mission

- Prevent progression from acute to chronic opioids
  - Lower unnecessary acute opioid prescribing
  - Intervene quickly after acute opioid prescribing “post-acute”
  - Avoid opioids for chronic pain
  - Lower overall opioid prescribing

- Reduce variation of opioid prescribing

https://edocs.dhs.state.mn.us/lfs/server/Public/DHS-7762-ENG
In 2016 ~5000 chronic daily opioid users were “created” in Minnesota.

We believe that number can be lowered
We wrestled, and continue to wrestle, with how to best manage the current chronic pain patients taking daily opioids.
Not OPWG goals:

- Not a comprehensive opioid strategy for the state
- Not a comprehensive pain strategy for the state
- Punish or hinder providers working in good faith
- Disincentivize care of Medicaid patients
- Worsen the care of patients in acute pain
- Make chronic opioid, chronic pain patients unstable
Marginal benefit of similar plan in another state:

How is MN different?

Barnett et al
NEJM 377; 24
Dec 14, 2017
Opioid prescriptions dispensed per 100 persons

By working with providers and providing information to the public, we hope to reduce the number of opioid prescriptions.

Minnesota opioid action plan 2-14-18
State opioid resources:

• Opioid provider work group information

• State opioid action plan 2/14/18

• MN Dept of Health Opioid indicator dashboard:
  • http://www.health.state.mn.us/divs/healthimprovement/opioid-dashboard/index.html

• MN Dept of Health Opioid plan website
  • http://www.health.state.mn.us/divs/healthimprovement/working-together/state-plans/opioidstateplan.html
The State’s priority for action:

- Acute prescribing rates
- Acute prescribing doses
- Cutting off opioids early
- Chronic prescribing rates
- Mixing chronic opioids and benzos
- High dose chronic prescribing
- Prescribing to “doctor shoppers”

https://edocs.dhs.state.mn.us/lfs/server/Public/DHS-7763-ENG
OPWG/OPIP interventions apply to...

- Nurse Practitioners
- Physician’s Assistants
- Doctors
- Dentists
- Residents, if prescribing from your own DEA license

(i.e. anyone who prescribes opioids to a Medicaid recipient)
Inpatient opioid prescribing exempted

Discharge opioid prescriptions do count!
Patients with cancer dx or hospice care are exempted
Patients prescribed methadone from an addiction clinic or buprenorphine/naloxone are exempted
These reports will only be seen by the provider and the state, no one else.

(If a QI project is assigned, the provider’s institution will be alerted)
First “report card” sent to you in Feb 2019 as a *baseline*: No QI projects!

Annual reports w/QI thereafter
10% of providers may trigger a threshold requiring action:

- Explanation of prescribing

or

- QI project on opioid prescribing
QI projects

• Will be defined in the coming months
• Not meant to be onerous
• Focused on:
  • Improvement of prescribing
  • Bring opioid prescribing nearer to community standard
  • Improvement of recognition of patient risk
  • Improvement of patient services
  • Keeping you credentialed
Failure to respond to a QI project result in removal of credentials to care for Medicaid patients
Failure to respond to a QI project result in removal of credentials to care for Medicaid patients

(Very unlikely!)
Definitions and details
MME: 
(Mg Morphine Equivalents)
Add up all types of opioids prescribed and express it as one measure

www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm
Daily MME: Daily opioid exposure

Important for chronic pain:

- Linearly correlated with mortality
- Inversely correlated to function, pain control, mental health, addiction stability, coping skills
Total MME:
Opioid exposure for the full episode of opioid treatment

Important for opioid naïve patients with acute pain:
- Correlated to likelihood of ongoing opioid use
Opioid Naïve: No (outpatient) opioid RXs in the prior 90 days

Index opioid prescription: First outpatient opioid to a naïve patient

Standard research definition
We tested 180 for validity (little difference)
Measure 1: Frequency of index opioid prescribing to opioid naïve patients
Measure 1: frequency index Rx

- #index opioid prescriptions over total Medicaid enrollees seen in one year
- 8% is the threshold for QI project
- This will affect a fraction of the highest quartile of prescribers: very few primary providers
## Surgical subspecialties at risk for measure 1

### Comparison between 1Q and 4Q average prescribing rate, by specialty group

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Quartile 1 Average Prescribing Rate</th>
<th>Quartile 4 Average Prescribing Rate</th>
<th>How many times higher the Q4 prescribing rate is than Q1 rate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist General</td>
<td>0.005</td>
<td>0.11</td>
<td>22</td>
</tr>
<tr>
<td>Dentist Surgical</td>
<td>0.112</td>
<td>0.647</td>
<td>5.7</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>0.012</td>
<td>0.088</td>
<td>7.3</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>0.008</td>
<td>0.07</td>
<td>8.75</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>0.005</td>
<td>0.057</td>
<td>11.4</td>
</tr>
<tr>
<td>OBGYN</td>
<td>0.013</td>
<td>0.142</td>
<td>10.9</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>0.018</td>
<td>0.154</td>
<td>8.6</td>
</tr>
<tr>
<td>Other PA APRN</td>
<td>0.008</td>
<td>0.122</td>
<td>15.25</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>0.002</td>
<td>0.036</td>
<td>18</td>
</tr>
<tr>
<td>Surgery</td>
<td>0.021</td>
<td>0.234</td>
<td>11</td>
</tr>
</tbody>
</table>
Measure 2:

High dose index opioid prescriptions
measure 2: High dose index opioid prescribing:

• #high dose index opioid prescription over #index prescription per year

• High dose opioid prescription:
  • Greater than 100 MME total for nonsurgical
  • Greater than 200 MME total if from a surgeon

• Threshold is >50% high dose
  • This will affect primary providers!
### Comparison: Quartiles by Prescribing Rate vs Quartiles by MME Rate

**Quartiles by Prescribing Rate**

<table>
<thead>
<tr>
<th>Quartile</th>
<th># of Index Rx</th>
<th>Distinct # of Recipients</th>
<th>Total MME</th>
<th>Median MME per Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>684</td>
<td>128,343</td>
<td>124,897</td>
<td>150</td>
</tr>
<tr>
<td>2</td>
<td>1,240</td>
<td>84,618</td>
<td>265,363</td>
<td>150</td>
</tr>
<tr>
<td>3</td>
<td>2,201</td>
<td>84,219</td>
<td>476,290</td>
<td>178.3</td>
</tr>
<tr>
<td>4</td>
<td>4,486</td>
<td>79,202</td>
<td>1,116,469</td>
<td>205</td>
</tr>
</tbody>
</table>

**Quartiles by MME Rate**

<table>
<thead>
<tr>
<th>Quartile</th>
<th># of Index Rx</th>
<th>Distinct # of Recipients</th>
<th>Total MME</th>
<th>Median MME per Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>841</td>
<td>125,682</td>
<td>85,438</td>
<td>100</td>
</tr>
<tr>
<td>2</td>
<td>1,435</td>
<td>85,970</td>
<td>203,248</td>
<td>150</td>
</tr>
<tr>
<td>3</td>
<td>2,296</td>
<td>87,279</td>
<td>434,728</td>
<td>187.5</td>
</tr>
<tr>
<td>4</td>
<td>4,039</td>
<td>77,451</td>
<td>1,259,605</td>
<td>298.9</td>
</tr>
</tbody>
</table>

7/20/2017

Minnesota Department of Human Services | mn.gov/dhs
What you need to do for measure 2:

Set your default to prescribe <100 MME for acute pain:

<20 X 5MG hydrocodone
<16 X 5MG oxycodone
Measure 3:

Number of patients receiving index opioid prescriptions who progress to *at risk* for chronic opioid use
Measure 3: 700 MME total for treatment episode

• #opioid prescriptions crossing 700MME for a treatment episode over index prescribing episodes
• Threshold set at 15%
  • *Will affect 25% primary prescribers*
• Meant to encourage early discontinuation of opioids in acute pain, prevent chronic opioid use
<700 total MME:

<140 hydrocodone 5 mg tablets
<112 oxycodone 5 mg tablets
If someone else gave the first 139 hydrocodone tablets, and you gave the 140th hydrocodone, that instance counts to your threshold.
Wide range in docs crossing the 700 MME threshold

Percent of opioid Rxs written in the post-acute interval that cross 700 MME threshold or exceed 700 MME, by specialty

MN DHS 2016 1.3 M patient years >600,000 opioid RX
What measure 3 demands of you

• 700 MME happens earlier than you might think—start planning opioid discontinuation at the first RX

• Check the PMP

• Develop skills communicating with patients about discontinuing opioids

• Limit continuation of opioids to severe cases of pain with objective findings of tissue damage
Overlap in Acute and Postacute measures

• The overlap between high frequency, high dose, and high total episode MME is >80%

• Put another way, if you receive one QI project, there is a good chance you will receive multiple
Measure 4:

Percentage of patients on chronic opioids for pain
Measure 4: Chronic Opioids for Pain

• #Prescribing chronic opioids over number of enrollees seen
• No threshold; no QI projects
• We want you to retain your relationship with these patients!
• In the short term we will be pushing the high dose patients into this category—this category may grow
Percent of enrollees prescribed at least 1 opioid Rx who received ≥ 60 or ≥ 90 days supply, by specialty

- Fam Med: 23 (60), 18 (90)
- Intern Med: 22 (60), 17 (90)
- Pain: 35 (60), 25 (90)
- Physical Med & Rehab: 44 (60), 35 (90)
- Psychiatry: 33 (60), 25 (90)
- Rheumatology: 57 (60), 46 (90)

9/20/2017
Measure 5:

Percentage of high dose chronic opioids prescriptions for pain
Measure 5: High opioid dose chronic pain patients

• 90 MME daily opioids
• #chronic opioid prescription >90 MME daily over number of chronic opioid patients
• Highly vulnerable and sensitive group
• This group requires comprehensive care
• Threshold for QI 10%
“COAT” chronic opioid analgesic therapy

Percent of enrollees prescribed high-dose COAT among all enrollees on COAT, by group

- **Primary Care**
  - 50 MME/60 days: 9, 9
  - 50 MME/90 days: 23, 24
  - 90 MME/60 days: 11, 12
  - 90 MME/90 days: 1, 0

- **Pediatrics**
  - 50 MME/60 days: 25, 27
  - 50 MME/90 days: 8, 9
  - 90 MME/60 days: 9, 9
  - 90 MME/90 days: 1, 0

- **Specialty**
  - 50 MME/60 days: 24, 25
  - 50 MME/90 days: 8, 9
  - 90 MME/60 days: 9, 9
  - 90 MME/90 days: 1, 0

- **All**
  - 50 MME/60 days: 24, 25
  - 50 MME/90 days: 8, 9
  - 90 MME/60 days: 9, 9
  - 90 MME/90 days: 1, 0
What measure 5 demands of you

• Talk to all patients on greater than 90 MME per day
• Work with them to lower their doses to <90 MME
• Retain your relationship with them
• Go slow tapering the dose
Measure 6:

Chronic opioid therapy plus benzodiazepines
Measure 6: Chronic opioids and benzodiazepines:

• #chronic opioid patients >50 MME with at least one week of benzodiazepine over #chronic opioid patients
• Threshold 10%
• Highly vulnerable and sensitive group
• Often both scripts come from the same provider
• Sometimes dependent on other prescribers (psychiatrist, emergency provider)
What measure 6 demands of you

• Never prescribe benzos and opioids together
• Check the PMP for other benzo prescribers
• Set expectations with patients including what will happen if they are prescribed from another source
• Repeat these expectations periodically
Measure 7:

“Doctor Shoppers”
Measure 7: “Doctor shoppers”

- #chronic opioid patients with 2 or more additional prescribers over #chronic opioid patients
- No threshold; no QI projects
- Encourage PMP use
- Dependent on other prescribers
PMP Queries inversely associated with patients receiving multiple prescriptions.
The State’s priority for action:

• **Acute prescribing rates** (<8% patients seen)
• **Acute prescribing doses** (<100 MME ½ time)
• **Cutting off opioids early** (<700 MME 85% time)
• Chronic prescribing rates (no threshold)
• High dose chronic prescribing (<90 MME in >90%)
• Mixing chronic opioids and benzos (<10%)
• Prescribing to doctor shoppers (check pmp)
This is a work in progress!
The overall goal is to:

1. Lower total opioid prescribing

2. Eliminate unneeded dangerous prescriptions

3. Lower the number of new daily opioid users created in the state
Thanks You!
Questions?