Meeting the Challenges of Opioids and PAIN

Clinical Tools for Minnesota

Thursday, June 21, 2018

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Meeting the Challenges of Opioids and PAIN
Thursday June 21, 2018

Today's Presenters:

Brad Johnson, MD Medical Director for South Country Health Alliance and a member of the Minnesota Opioid Prescribing Work Group

Patty Graham Senior Quality Consultant, HealthPartners

Webinar Objectives

- Identify key components in the MN Opioid Prescribing Guidelines.
- Identify important elements when educating patients about pain and non-pharmacological alternatives
- Understand how to effectively utilize the Opioid Provider toolkit

Disclaimer

- I have participated on the **O**pioid **P**rescribing **W**ork **G**roup (**OPWG**) monthly meetings since July 2017 as the Health Plan Medical Director representative.
- I do not claim to be a pain management specialist or spokesperson representing the OPWG guideline recommendations.

Authority of Opioid Prescribing Improvement Program

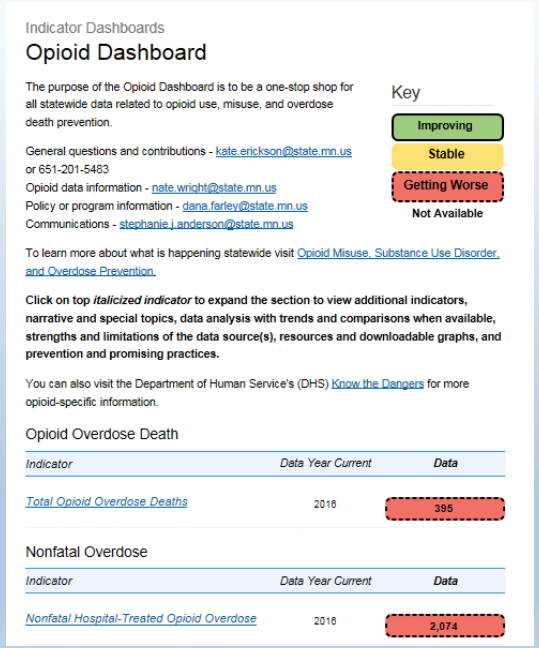
- 2015 Minnesota Legislature passed statute **256B.0638** authorizing the Opioid Prescribing Improvement Program.
  - https://www.revisor.mn.gov/statutes/cite/256B.0638
- The statute called for the formation of the Opioid Prescribing Work Group (OPWG) made up of 14 voting members including physicians, pharmacists, consumers, dentist, nurse practitioner, law enforcement, health plan medical director, mental health professional, and non-physician health professionals who treat pain.

Objective of Opioid Prescribing Improvement Program (OPIP)

- Reduce opioid dependency and substance abuse that is related to the prescribing of opioid analgesics by health care providers.

Desired outcomes of Opioid Prescribing Improvement Program (OPIP)

1. *Prevent the progression from opioid use for acute pain to new chronic opioid use.*
2. *Reduce variation in opioid prescribing behavior*
3. *Provide prescribers with resources to communicate with their patients about pain and opioid use*



Indicator Dashboards

Opioid Dashboard

The purpose of the Opioid Dashboard is to be a one-stop shop for all statewide data related to opioid use, misuse, and overdose death prevention.

General questions and contributions - kate.erickson@state.mn.us or 651-201-5483
Opioid data information - nate.wright@state.mn.us
Policy or program information - dana.farley@state.mn.us
Communications - stephanie.j.anderson@state.mn.us

Key

Improving
Stable
Getting Worse
Not Available

To learn more about what is happening statewide visit Opioid Misuse, Substance Use Disorder, and Overdose Prevention.

Click on top *italicized indicator* to expand the section to view additional indicators, narrative and special topics, data analysis with trends and comparisons when available, strengths and limitations of the data source(s), resources and downloadable graphs, and prevention and promising practices.

You can also visit the Department of Human Service's (DHS) Know the Dangers for more opioid-specific information.

Opioid Overdose Death

Indicator	*Data Year Current*	***Data***
Total Opioid Overdose Deaths	2016	395

Nonfatal Overdose

Indicator	*Data Year Current*	***Data***
Nonfatal Hospital-Treated Opioid Overdose	2016	2,074

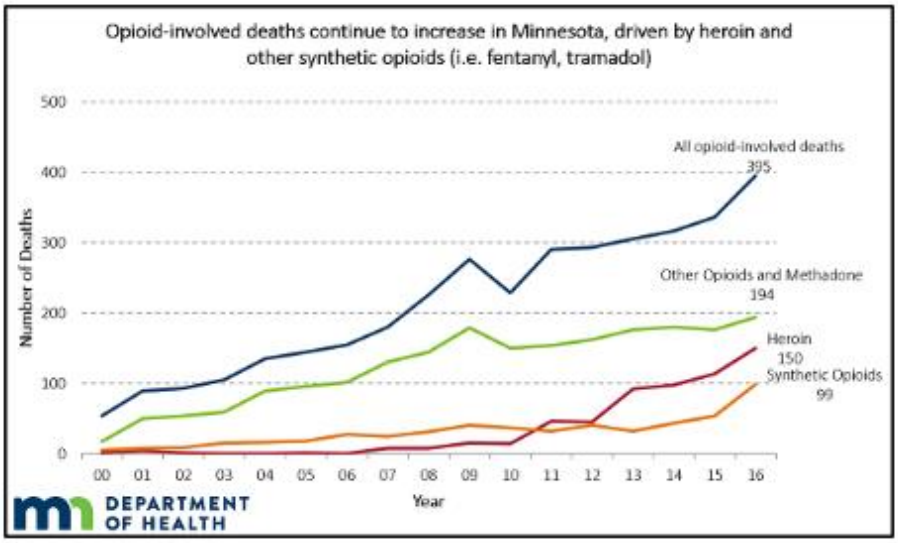
http://www.health.state.mn.us/divs/healthimprovement/opioid-dashboard/

MDH Opioid Dashboard

Opioid Overdose Death

Indicator	*Data Year Current*	***Data***
Total Opioid Overdose Deaths	2016	395
Opioid Overdose Deaths by Drug Category	2016	Prescription: 194 Heroin: 150

Opioid-involved deaths in Minnesota 2000 to 2016



Minnesota Opioid Prescribing Guideline Recommendation Development Timeline

- 2015 Legislative session: Established Opioid Prescribing Improvement Program
- Dec. 2015 – First monthly OPWG meeting
- March 2016 – CDC released Guidelines for Opioids for Chronic Pain
- Dec. 2017 – Opioid Prescribing Guideline *Draft* Recommendations released for 30-day comments
- March 2018 – Commissioner Emily Piper, DHS and Commissioner Jan Malcolm, MDH approve and release First Edition of Minnesota Opioid Prescribing Guidelines
- 2018 – DHS contracted with Weber Shandwick to develop educational resources for prescribers

MINNESOTA

Minnesota Opioid Prescribing Guidelines

First edition, 2018

https://mn.gov/dhs/assets/mn-opioid-prescribing-guidelines_tcm1053-337012.pdf

Minnesota Opioid Prescribing Guidelines

https://mn.gov/dhs/opioid-guidelines/

Part I
- Patient Safety Recommendations
- Biopsychosocial and Risk Assessment
- Non-Opioid and Non-pharmacologic Pain Management

Part II
- Opioid Prescribing for Acute Pain

Part III
- Opioid Prescribing for Post-Acute Pain

Part IV
- Opioid Prescribing for Chronic Pain

Part V
- Tapering or Discontinuing

Part VI
- Women of Childbearing Age

Minnesota Opioid Prescribing Guidelines

https://mn.gov/dhs/opioid-guidelines/

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MN Opioid Prescribing Guidelines Focus on Opioid Therapy During Three Phases of Pain

Acute Pain:

Pain occurring during the first 4-7 days after an acute event.

Post-Acute Pain:

Pain occurring up to 45 days following an acute event.

Chronic Pain:

Pain lasting >45 days after an acute event; or beyond the normal expected time of tissue healing.

*chronic pain is not just prolonged acute pain

Acute Pain Phase

"pain during the first 4-7 days after an acute event"

- Most experts agree that acute pain caused by major trauma or some outpatient procedures can be effectively managed with up to 100 MME* total dose or <3 days supply of pain meds.

*MME (Morphine Milligram Equivalence) additional information in Appendix C of the Opioid Prescribing Guidelines

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-Aug-2017.pdf

Morphine Milligram Equivalence

Morphine Milligram Equivalence Conversion Factors

Table 1. MME Conversion Factors	
Type of Opioid	**MME Conversion Factor**
Codeine	0.15
Dihydrocodeine	0.25
Fentanyl transdermal	7.2
Hydrocodone	1
Hydromorphone	4
Morphine	1
Oxycodone	1.5
Oxymorpohone	3
Tramadol	0.1

Example:
Oxycodone 5mg q6h x 3 days = 12 tabs = 90 MME

Post-acute Pain Phase

"pain occurring up to 45 days following an acute event"

- Analysis of the MHCP population:
  - nearly 80% of the individuals who receive at least a 45 day supply of opioids go on to receive a 90 days' supply over 6 months
- TROUP Study, Gen Intern Med 2011;26:1450-57
  - 65% of individuals who receive a 90 day supply of opioids continue opioid use at 3 years
- The post acute pain period is the critical timeframe to halt the progression to chronic opioid use.
- Clinicians should increase assessment of the biopsychosocial factors associated with opioid-related harm and chronic opioid use during the post-acute pain period.

Chronic Pain Phase*

"Pain lasting >45 days after an acute event; or beyond the normal expected time of tissue healing"

- The evidence to support chronic opioid analgesic therapy for chronic pain is insufficient at this time, but the evidence of harm is clear.

*excluding cancer, palliative, and end-of-life care

Acute Pain Phase - Clinical Recommendations

14 recommendations

1. Use multimodal analgesia
2. Document pain and physical function
3. Know risk factors for opioid-related harm
4. Check the PMP
5. Avoid prescribing entire prescription of > 100 MME
6. Limit the initial prescription to no more than 200 MME
7. Use non-opioid analgesics to manage acute oral pain
   - Refer to a dental provider
8. Avoid prescribing > 100 MME total supply following a dental procedure
9. Avoid prescribing opioids when history of SUD

Acute Pain Phase - Clinical Recommendations

14 recommendations

10. Consult a DATA* waived prescriber when prescribing opioids to a patient receiving buprenorphine for OUD and limit opioid analgesia to 100 MME total to patients on methadone
11. For COAT** patients, dosage for a new injury will be the same as any patient not already on opioids
12. Co-manage acute pain in COAT patients with COAT prescriber, pain specialist, psychologist, anesthesiology
13. For COAT patients, do not increase opioid dosage for exacerbation of chronic pain, offer non-opioid treatment
14. Check PMP for all children prescribed opioids to avoid risk of parental diversion

*DATA = Drug Addiction Treatment Act of 2000 allows physicians to become certified to prescribe buprenorphine for opioid addiction

**COAT = Chronic Opioid Analgesic Therapy

Post-Acute Pain Phase - Clinical Recommendations

9 recommendations

1. Document pain and function at each follow-up visit
2. Reevaluate the etiology of the pain for those not demonstrating expected improvement in pain
3. Assess and document risk factors for opioid-related harm and progression to chronic opioid use
   - Depression, anxiety, substance abuse, fear avoidance
4. Introduce multi-modal pain management therapy
5. Prescribe opioids in multiples of 7-days with limit of 200 MME per 7 days period
6. Avoid prescribing in excess of 700 MME (cumulative)
7. Taper opioid therapy as tissue healing progresses
8. For patients on COAT prior to the acute injury, taper the dose toward the pre-injury opioid dosage as tissue heals
9. Develop a referral network for mental health, SUD, pain education, pain medicine

Chronic Pain - Clinical Recommendations

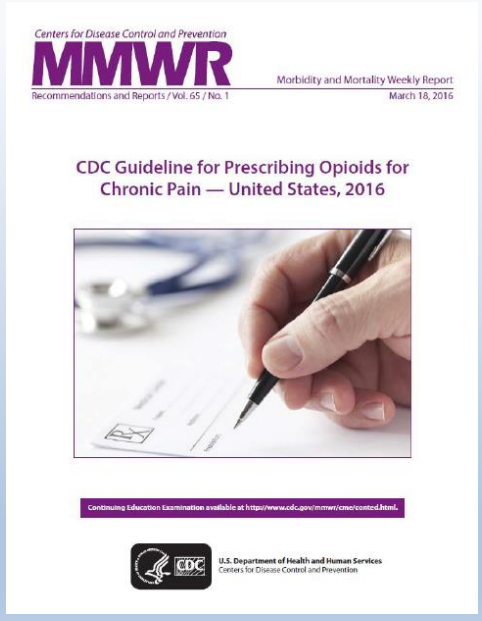
18 recommendations

1. Assess mental health conditions prior to initiating COAT
2. Establish measurable treatment goals prior to initiating COAT
3. Assess potential barriers to active participation with treatment
4. Offer access to care coordination across providers
5. Initiate a patient provider agreement prior to initiating COAT
6. Try to keep daily dosage < 50 MME/day and avoid increasing the daily dosage to > 90 MME/day
7. Limit prescriptions to one month duration and face to face encounters at least every 3 months
8. Offer to reduce or discontinue every face-to-face visit
9. Avoid initiating COAT for patients with untreated SUD or history of SUD

Chronic Pain - Clinical Recommendations

18 recommendations

10. Prescribe short acting opioids when initiating COAT
11. Avoid routine rotation or substitution of Opioids
12. Avoid using methadone interchangeable with long acting opioids for chronic pain
13. Exercise extreme caution when considering fentanyl for pain
14. Urine Drug Screen prior to initiating COAT and random 2x/yr.
15. Pill count call backs for high risk patients
16. Monitor COAT patients for OUD
17. Arrange evidence-based treatment for patients with OUD
18. Consider consulting specialists trained in pain, addiction, or mental health conditions when initiating COAT



https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf

Other Clinical Recommendations

- Patient Safety
  - 11 recommendations
- Biopsychosocial Assessment
  - 10 recommendations
- Non-opioid & Non-Pharmacologic Treatment Modalities
  - 5 recommendations
- Tapering and Discontinuing Opioid Use
  - 4 recommendations
- Women of Childbearing Age
  - 6 recommendations

A Provider Toolkit

Meeting the Challenges of Opioids and PAIN:

PATIENT EDUCATION ON PAIN AND OPIOID PRESCRITIONS

ADDRESSING OPIOID PRESCRIPTION PRACTICES

IDENTIFYING SAFE AND EFFECTIVE PAIN MANAGEMENT PROTOCOLS

NONPHARMACOLOGIC AND NON-OPIOID PHARMACOTHERAPY ALTERNATIVES

Table of Contents

The Opioid Provider Toolkit includes a benefit grid to assist providers in recommending Alternative Pain Management Therapies for Medicaid patients.

Category	Intervention	Medicaid Benefit Coverage
Interventional & Behavioral	Mirror therapy (treatment of phantom limb pain; induction of limb imagery)	May be covered under Physical Therapy if ordered and rendered by an appropriate qualified provider.
	Osteopathic Manipulative Treatment • Spinal manipulation	Covered under Chiropractic if member meets criteria & services are ordered and rendered by a qualifying provider.
	Biofeedback	Not separately reimbursed – may be covered if ordered & rendered by an appropriate qualified provider.
Interventional & Physical	Physical Therapy	Covered if member meets medical criteria & services are ordered & rendered by an appropriate qualifying provider.
	General Chiropractic treatment for pain	Covered for manual manipulation of the spine to treat subluxation of the spine & related x-rays if ordered & rendered by an appropriate qualifying provider.

Go to **StratisHealth.org/PIP/Opioids.html** and under resources you can access the **Alternative Pain Management Therapies – Minnesota Medicaid Benefit Coverage** grid

Thank you!

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QUESTIONS

32