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# Legislative Report

## Opioid Prescribing Improvement Program

September 2019

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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 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:

- Update on the Opioid Prescribing Work Group's efforts to date;
- Summarize activities related to the release of the Minnesota Opioid Prescribing Guidelines in April 2018. The summarized guidelines are found in Appendix B and in their entirety on the [DHS web site](#);
- Describe the Opioid Prescribing Improvement Program sentinel prescribing measures (Appendix C);
- Summarize the newly developed provider education campaign, [Flip the Script](#) (Appendix E);
- Update on the Minnesota Health Care Programs (MHCP) Quality Improvement Program, which includes sentinel measures, prescribing reports and quality improvement efforts;
- Provide trend data on opioid prescribing within the MHCP for 2016, 2017 and 2018, as well as data that illustrate the variation in opioid prescribing; and
- Summarize the partnerships developed between DHS and provider organizations support the work of the OPIP.

## 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

Opioid dependency and abuse continue to be a significant public health concern in Minnesota. In 2018, opioids were responsible for 331 deaths, according to preliminary data the Minnesota Department of Health. This number represents a 17% decrease from 422 deaths in 2017, indicating the first decrease in opioid related deaths since 2010<sup>1</sup>. Opioid related deaths are divided into three categories: a) synthetic opioids, such as fentanyl, b) other opioids and methadone and c) heroin. While the latter two categories saw a 33% and 23% decrease in deaths respectively, deaths related to synthetic opioids increased by 5%. The overall trends are promising, however, harm associated with prescription opioids remains substantial and requires continued focus.

Data provided by the Minnesota Board of Pharmacy demonstrate that opioid prescribing rates remain significantly higher than they were prior to the onset of this public health crisis. According to Minnesota's Prescription Drug Monitoring program, administered by the Board of Pharmacy, there were an average of 517.5 opioid prescriptions dispensed for every 1000 residents in 2017.<sup>2</sup> A review of county-level prescribing rates in Minnesota indicate a three-fold difference between the lowest reported prescribing rates (273 scripts for every 1000 residents) and the highest (971 for every 1000 residents) (Houston and Aitkin counties, respectively). This degree of variation in opioid prescribing can indicate problematic prescribing patterns in ways that have geographic, racial and socio-economic implications. Variation in prescribing occurs at the national, state, and local levels.

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) that is related to the prescribing of opioid analgesics by health care providers. The OPIP is a unique community supported effort to improve prescriber practice via a community wide improvement process tied to Medicaid providers. The OPIP aims to balance the evidence for the use of opioids to treat certain types of pain with the inherent risks that these medications pose to individuals and communities.

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.

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<sup>1</sup> Minnesota Department of Health. [Preliminary 2018 Drug Overdose Deaths Report](#). July 9, 2019.

<sup>2</sup> Minnesota Board of Pharmacy. [Minnesota Prescription Drug Monitoring Program 2017 Annual Report](#) .July 24, 2018.

- Recommend quality-improvement measures to assess variation and support improvement in clinical practice;
- Recommend two sets of thresholds directed at MHCP-enrolled providers with persistently concerning prescribing practices, one threshold set that will trigger quality improvement and the other termination from MHCP;

Pursuant to the authorizing statute, the opioid prescribing protocols do not apply to opioids prescribed for patients who are experiencing pain caused by cancer or who are receiving hospice care, or to opioids prescribed to treat opioid use disorder.

## IV. Report Content

### 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 legislation. Appendix A lists the OPWG members, including the statutorily set membership categories.

In October 2017, the Commissioner of Human Services authorized a two-year extension of the OPWG, pursuant to Minnesota Statute § 15.059, Subdivision 6. The purpose of extending the OPWG through December 2019 was to reconvene members to accomplish the following three tasks, work on which is presently underway:

- 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 (PMP));
- Develop thresholds, based on continued aberrant opioid prescribing behavior, that will guide provider disenrollment from the MHCP; and
- Develop special cause exemption criteria for prescribers whose practice warrants prescribing outside of the quality improvement thresholds (e.g., orthopedic surgeons who only perform major joint replacement).

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 completed extensive work since the last legislative report issued on September 2018 which is summarized in the call-out box below. The OPWG has a dedicated [web page](#) and DHS staff maintain a dedicated [email address](#) for communications pertaining to the OPIP work. Community members may also 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.

<b>2019 OPIP MILESTONES</b>
<p><b>November 2018:</b> DHS' New Chronic User measure was reviewed by the National Committee for Quality Assurance (NCQA) and adapted to be a HEDIS 2019 measure, <i>Risk of Continued Opioid Use</i>.</p>
<p><b>January 2019:</b> OPWG approved volume thresholds for quality improvement; providers who see fewer than ten enrollees are not subject to quality improvement.</p>
<p><b>March 2019:</b> DHS launched "Flip the Script", a provider education campaign aiming to change the narrative around prescription opioid therapy, pain management and prescription opioid misuse.</p>
<p><b>June – August 2019:</b> First round of individual provider reports issued to roughly 16,000 MHCP providers.</p>

## **Minnesota Opioid Prescribing Guidelines**

Governor Dayton announced the final Minnesota Opioid Prescribing Guidelines at a press conference on April 4, 2018. The complete Minnesota Opioid Prescribing Guidelines can be found on the Department of Human Services [web site](#). A summary of the guidelines is provided in Appendix B.

## **Provider Educational Tools & Resources**

In collaboration with the medical community, DHS developed a provider awareness campaign that was announced in March 2019. The "Flip the Script" campaign aims to change the narrative around prescription opioid therapy, pain management and prescription opioid misuse in Minnesota (Appendix E). Health care professionals are urged to "flip the script" when speaking with their patients about opioids and pain management.

Derived from qualitative provider interviews, the campaign helps providers overcome one of the biggest barriers faced in the clinical setting - difficult conversations around mental illness, substance abuse and stigma.

The [Flip the Script](#) campaign offers a variety of flexible, resources for health care professionals including:

- Discussion guides to support conversations with patients around the risks associated with long-term opioid therapy, tapering, and opioid alternatives to pain management,
- A [video testimonial](#) from one Greater Minnesota doctor who changed his opioid prescribing practices and ended up improving his relationship with his patients and how he thinks about his work.
- A [podcast](#) developed in partnership with the University of Minnesota about the Minnesota Opioid Prescribing Guidelines. Although available to all audiences, the online learning activity offers physicians, pharmacists and nurses an opportunity to earn continuing education credits for learning more about the guidelines on safe opioid prescribing behavior.

## OPIP Sentinel Measures

The OPIP sentinel measures were developed as a companion to the Minnesota Opioid Prescribing Guidelines. OPIP uses the term “sentinel measure” to signal the need for a consistent and robust response to opioid prescribing patterns that exceed the community agreed-upon standards. An overview of the OPIP sentinel measures and quality improvement thresholds is provided in Appendix C.

A brief description of the seven OPIP sentinel measures are provided below:

1. Index opioid prescription prescribing rate
2. Index opioid prescription: prescribing rate over recommended dose (100 morphine milligram equivalents (MME) or 200 MME)
3. Rate of prescribing 700 cumulative MME or more during an initial opioid prescribing episode
4. Chronic opioid analgesic therapy (COAT) prescribing rate
5. Rate of prescribing high-dose COAT
6. Rate of prescribing concomitant COAT and benzodiazepine therapy
7. Rate of prescribing COAT to patients with multiple opioid prescribers

## OPIP Prescriber Reports

Subsequent to the issuance of the Minnesota Opioid Prescribing Guidelines and the development of the sentinel measures, DHS analyzed 2018 opioid prescribing data for all MHCP prescribers and created individualized prescribing reports. The primary purpose of the DHS prescriber reports is to serve as a basis for quality improvement, educating providers about their own prescribing, particularly as it relates to their clinical peers.

The reporting mechanism was developed using data from DHS medical and pharmacy claims. It includes enrolled providers who prescribed at least one outpatient opioid prescription to an MHCP member in either fee for

service or managed care. Each provider received an individualized report comparing their prescribing behaviors to their anonymized peers. A sample report is included in Appendix D.

In June 2019 the first reports were issued to providers who had previously registered for a MN-ITS mailbox. The MN-ITS system was identified as the preferred delivery method for the reports as it was the most cost-effective and most secure. However, only 1359 providers were registered for MN-ITS mailboxes when the first reports were issued. Providers were strongly encouraged to register for MN-ITS and an additional 1379 providers received reports in August via newly created MN-ITS accounts. The remaining 13,659 letters were sent via US Mail. Providers and other stakeholders were offered three different avenues for support including the Provider Call Center, a dedicated email account ([dhs.opioid@state.mn.us](mailto:dhs.opioid@state.mn.us)) and an online form.

Baseline reports are intended to help providers self-identify potentially problematic prescribing behaviors. If a provider's first report indicates prescribing practices that are outside of community standards, providers are expected to evaluate their prescribing data. Moreover, they are encouraged to engage in activities that would correct problematic prescribing practices including, but not limited to, continuing education.

The initial prescribing reports mark the first phase of DHS' quality improvement program (QI) for opioid prescribing

## OPIP Quality Improvement Program

Pursuant to the legislation, DHS is currently implementing an opioid prescribing quality improvement program for MHCP-enrolled providers. The first component of quality improvement is the prescriber reports described in the section above. The subsequent components of the QI program are as follows:

- **2020 Reports:** Next year DHS will issue an updated set of prescribing reports and identify prescribers in need of quality improvement. Any provider who is outside the threshold on any of the five sentinel measures that have thresholds (two do not have thresholds) will be identified for mandatory quality improvement.
- **Special Cause Exemptions:** Under the guidance and direction of the OPWG, DHS staff will finalize special cause exemptions—circumstances that can release providers from mandatory quality improvement. The process and criteria for special cause exemptions will be developed before the 2020 quality improvement phase is launched.
- **Quality Improvement components:** The OPWG will determine specific quality improvement components approved for MHCP providers.
- **Future Reports:** Using the same process and data as in 2019 and 2020, prescribing reports will be issued to providers annually. Those who have improved and/or maintained prescribing practices within the community standards, will continue their good work. Prescribers who have been engaged in QI and who have not made adequate progress will then be identified for disenrollment from MHCP.
- **Disenrollment:** A significant task for the OPWG will be to determine disenrollment criteria for those providers who continue to remain outside of community standards for prescribing opioids.

## Opioid Prescribing Data

### Overall trends in opioid prescribing to Minnesota Health Care Programs enrollees: Decreases observed from 2016 to 2018

DHS staff continually 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 2017 to 2018. In 2018, there were 565,877 opioid prescriptions filled for MHCP enrollees (excluding patients with cancer and who receive hospice services).
- New opioid prescriptions for acute pain: There was a 11% decrease in the total number of index opioid prescriptions filled by MHCP enrollees from 2017 to 2018. 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 2018, there were 117,877 index opioid prescriptions filled.
- Chronic Opioid Analgesic Therapy (COAT): In 2018, there were 16,252 COAT recipients, marking a 26% decrease from 2017. 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 2017 to 2018. Figure 1 indicates the seven-year trend for chronic opioid use.

**Figure 1. Annual number of new chronic opioid users in the Minnesota Health Care Programs enrollee population, 2012-2018**

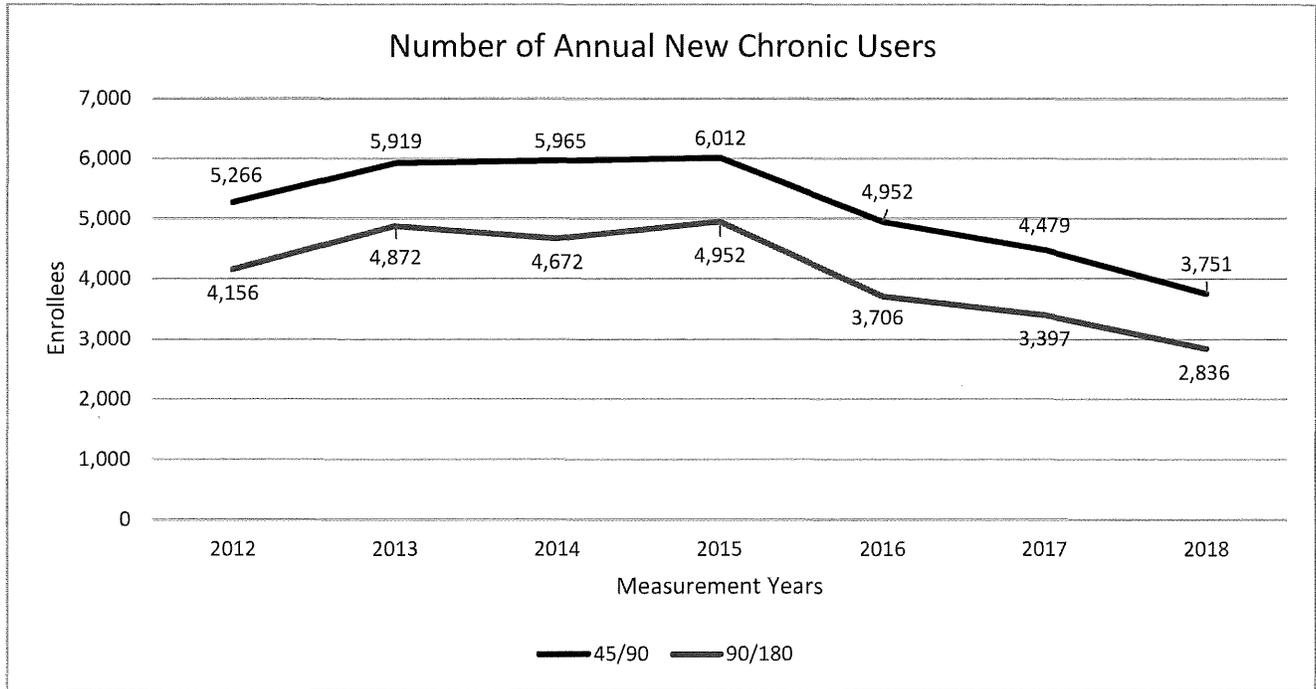


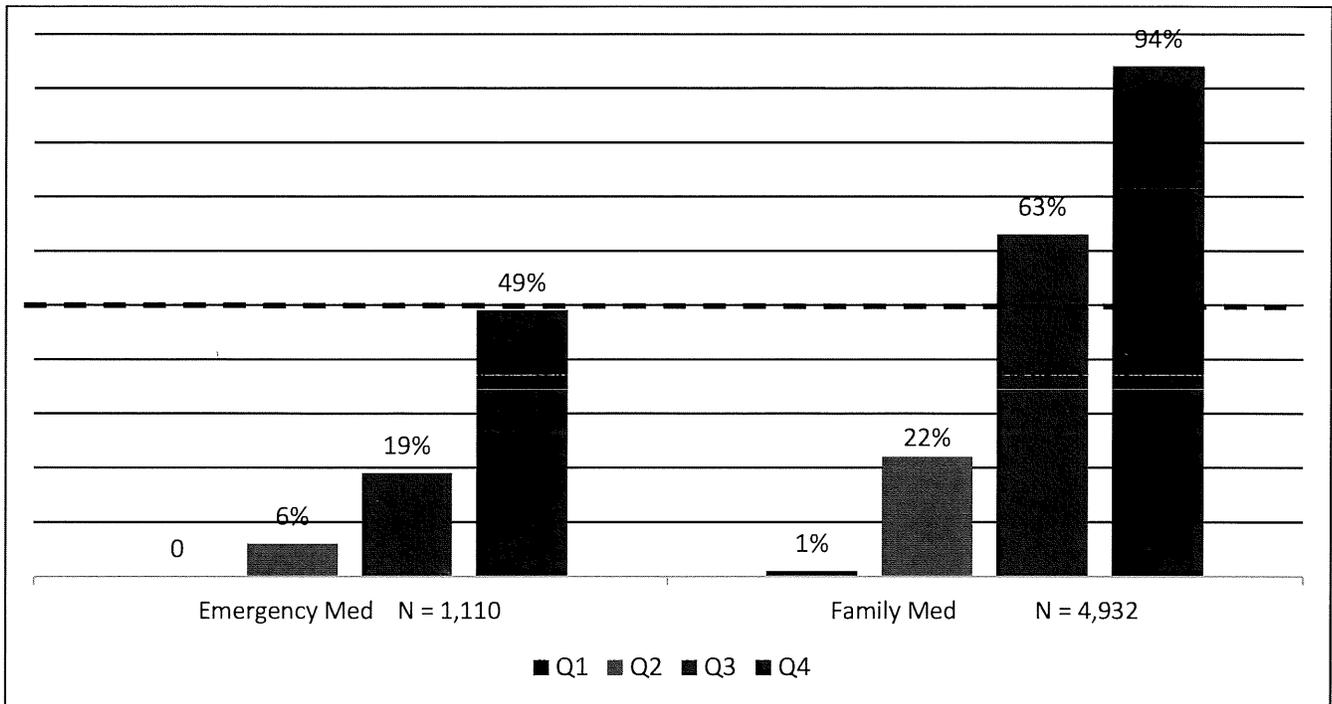
Figure 1 provides the number of New Chronic Users in the MHCP population from 2012 to 2018. New Chronic Use is defined as the number of enrollees who were previously opioid naïve (no opioid prescription in a 90-day look back period) who then receive 45 days or more of opioids in the 90 days following the index opioid prescription.

**Variation in opioid prescribing behavior among Minnesota Health Care Programs enrolled health care providers**

Variation in opioid prescribing can indicate problematic prescribing patterns. When providers are grouped by specialty with their clinical peers, variation should be minimal, unless explained by factors such as differences in the patient populations and severity of disease. However, as the charts below reveal, there is significant variation in prescribing practices between providers in the lowest and highest quartiles of their specialty areas.

Figures illustrates the variation found in the number of opioids prescribed for an index opioid prescription in emergency and family medicine providers. The measure is the percent of index opioid prescriptions that exceeded 100 MME or 200 MME in the calendar year. The 100 MME limit is applied to non-surgical provider groups, and the 200 MME limit is applied to surgical specialty groups.

**Figure 2. The percent of index opioid prescriptions that exceeded 100 MME, by quartiles in Emergency and Family Medicine, 2018**



*How to interpret the chart: In 2018, 1,110 Emergency Medicine providers, for example, prescribed an index opioid prescription to at least one MHCP enrollee. The providers are divided into equal groups based on their prescribing rate of index opioid prescriptions greater than 100 MME. Providers in Quartile 1 (Q1) are those with the lowest prescribing rates; providers in quartile 4 (Q4) are those with the highest prescribing rates. The rate of prescribing an index opioid prescription that was greater than 100 MME was calculated for each Emergency Medicine provider. The number displayed above each bar is the average rate of prescribing greater than 100 MME within each quartile. The dashed line indicates the quality improvement threshold rate (Rate = 50%). Providers whose prescribing rate is above the dash line would have been required to participate in a quality improvement review.*

This degree of variation exists across all specialty areas and is not unique to just emergency and family medicine.

The quality improvement program will recognize special cause variations for prescribers whose practice warrants prescribing greater than the recommended dose for the initial opioid prescription. For example, orthopedic surgeons who predominately perform major joint replacement surgeries may apply for a special cause variation and may not be required to participate in a quality improvement review.

## Partnerships and Dissemination

The spirit and intent of the OPIP program is that the work be highly collaborative, involving clinical and community partners. The following partners have engaged with DHS on various aspects of the OPIP work:

1. Institute for Clinical Systems Improvement (ICSI)

ICSI continues to be an important partner in this work. A representative from ICSI presented at the February meeting of the OPWG and shared the recent work of ICSI's MN Health Collaborative. The MN Health Collaborative has been working to improve opioid prescribing in both surgical and non-surgical prescribing practices and now offers members guidance on both. ICSI and DHS staff confer periodically to discuss how our respective projects can best complement each other.

2. Minnesota Hospital Association (MHA)

DHS partnered with MHA to assist with a number of efforts including dissemination of the Opioid Prescribing Guidelines and the sentinel measures. DHS also contracted with MHA to incorporate the sentinel measures into clinical workflows of MHA member organizations, as well as to develop sample quality improvement plans. After the first round of prescriber reports were issued in June, MHA organized a webinar in which DHS staff introduced providers to the opioid prescribing reports. MHA published its own Opioid Adverse Drug Event (ADE) Prevention Road Map which references DHS' opioid prescribing guidelines. A link to MHA's ADE Prevention Roadmap can be found [here](#).

3. Minnesota Medical Association (MMA)

MMA has been a key partner in disseminating opioid prescribing information to its 10,000+ members, physicians, residents and medical students. The association also offers its own set of [MMA Opioid Guidelines](#). DHS has worked with MMA to record webinars related to the OPIP program (webinars are not yet published).

4. University of Minnesota Academic Health Center

DHS is partnering with the University of Minnesota's School of Continuing Development in the Academic Health Center to distribute education about the prescribing guidelines and quality improvement program. The first [podcast](#) was available for continuing education credit in February of 2019. DHS also contributed to a core medical school course entitled "Becoming a Doctor" where medical students will gain insights about difficult conversations with patients about prescription narcotic use and abuse.

## 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, University of MN College of Pharmacy – Duluth Campus (pharmacist)
- Dana Farley, MS, Minnesota Department of Health (nonvoting)
- Rebekah Forrest, RN, CNP, North Point Community Clinic (nurse practitioner)
- Ifeyinwa Nneka Igwe, MD, Essentia Health (physician)
- Bradley Johnson, MD, South Country Health Alliance (health plan medical director)
- Ernest Lampe, MD, Minnesota Department of Labor and Industry (DLI medical consultant; nonvoting)
- Matthew Lewis, MD (not practicing), Medtronic (consumer representative)
- Peter 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)
- Detective Charles Strack, Little Falls Police Department (law enforcement)
- Lindsey Thomas, MD, Hennepin County Medical Examiner's Office, retired (medical examiner)
- Vacant, Minnesota Department of Human Services (MHCP medical director; nonvoting)

## 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 at this time, 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.
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 $\geq 60$ consecutive days' supply of opioids from any number of prescriptions. A $\leq 3$ 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.

Terms	Definition
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.

<b>Percent of enrollees prescribed an index opioid prescription</b>	<b>Distinct number of patients with one or more index opioid prescriptions prescribed in the measurement period</b>	<b>Distinct number of patients seen by the provider in the measurement period</b>	<b>Prescribing rate is &gt; 8% (non-surgical specialties only)</b>
<b>Percent of index opioid prescriptions exceeding the recommended dose</b>	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%
<b>Percent of prescriptions exceeding 700 cumulative MME in the post-acute pain phase</b>	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%
<b>Percent of patients with chronic opioid analgesic therapy (COAT)</b>	Number of patients with a prescription during a COAT period ( $\geq 60$ 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
<b>Percent of COAT enrollees exceeding 90 MME/day (High-dose COAT)</b>	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%
<b>Percent of enrollees receiving elevated dose COAT who received a concomitant benzodiazepine</b>	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%
<b>Percent of COAT patients receiving opioids from multiple prescribers</b>	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



## Your 2018 Opioid Prescribing Report

This report compares your opioid prescribing to your peers in your specialty in 2018, and is intended to support quality improvement. The data are for Minnesota Medicaid and MinnesotaCare members only. 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: 999999999

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

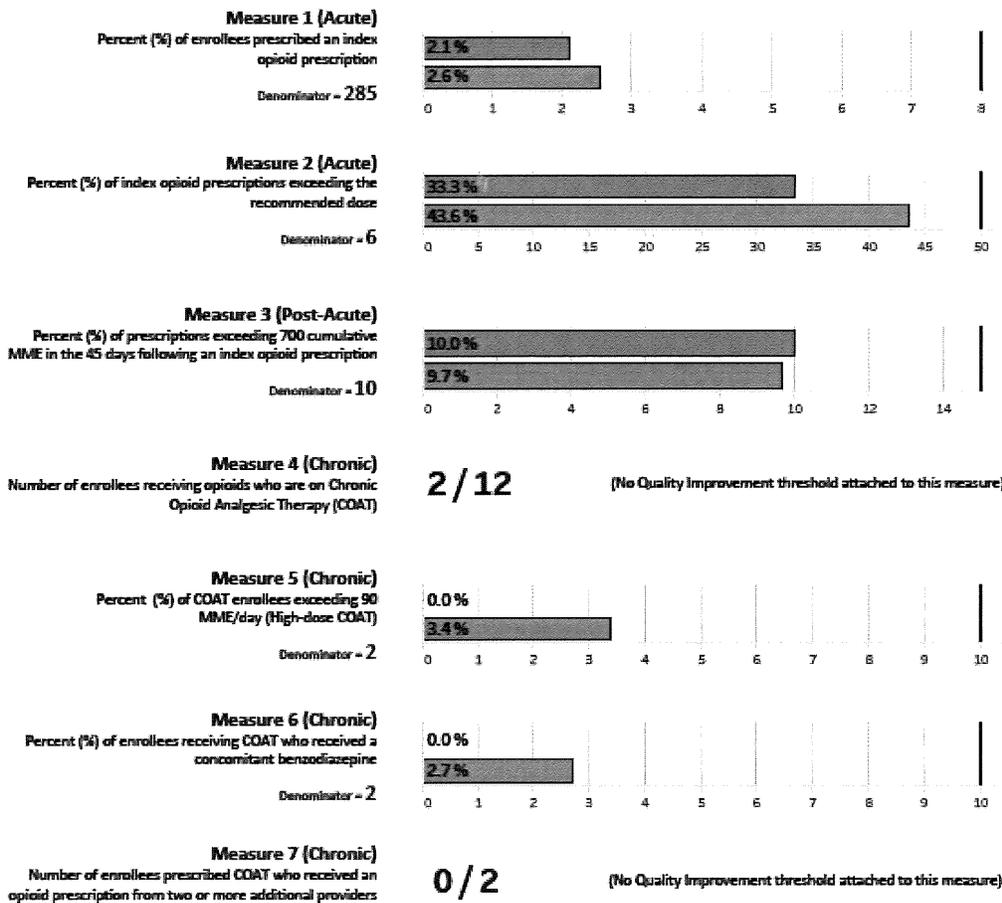
**Legend**

Your Percent (%) **2.1**

Average % of Your Specialty **2.6**

Quality Improvement Threshold: Red Line

Denominator = (Denominator of measure)

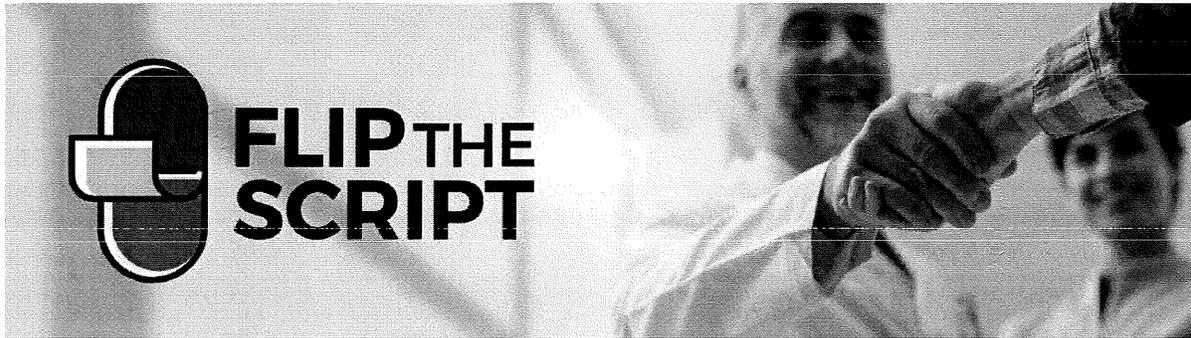


This report is for your review. Please note that continued prescribing above the quality improvement threshold in 2019 will require participation in a quality improvement program beginning in 2020. More information is available at: <https://mn.gov/dhs/opip>

Submit comments or questions about your report at the Opioid Prescribing Improvement Program website here: <https://mn.gov/dhs/opip/quality-improvement-program/>

## Appendix E. “Flip the Script” Provider Materials

# Opioid Prescribing Improvement Program



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 2016-2018

Table 1 represents data trends for acute and post-acute prescribing

	2016	2017	2018
<b>MHCP Enrollees</b>	1,224,566	1,218,898	1,232,690
<b>Opioid Prescriptions</b>	788,383	684,334	565,877
<b>Enrollees receiving opioids</b>	192,785	172,284	151,204
<b>Opioid Prescribers</b>	16,975	16,589	16,397
<b>Index Opioids</b>	152,132	132,664	117,877
<b>Index Opioids &gt; 100 MME</b>	78,354	64,943	51,910
<b>% Index Opioids &gt; 100 MME</b>	51.5%	49.0%	44.0%
<b>Opioid Rx in initial prescribing episode</b>	224,441	194,257	169,537
<b>Opioid Rx in initial episode &gt; 700 MME</b>	26,055	21,428	16,824
<b>% opioid Rx in initial episode &gt; 700 MME</b>	11.6%	11.0%	9.9%

Table 2 represents data trends for chronic prescribing

	2016	2017	2018
<b>MHCP Enrollees</b>	1,224,566	1,218,898	1,232,690
<b>Enrollees Receiving Opioids</b>	192,785	172,284	151,204
<b>Opioid Prescribers</b>	16,975	16,589	16,397
<b>COAT Recipients</b>	21,667	19,001	16,252
<b>High-dose COAT Recipients</b>	3,020	2,461	1,812
<b>% high-dose COAT recipients</b>	13.9%	13.0%	11.1%
<b>COAT recipients with concomitant benzodiazepines</b>	2,541	1,978	1,446
<b>% COAT recipients with concomitant benzodiazepines</b>	11.7%	10.4%	8.9%
<b>COAT recipients with 2 additional prescribers</b>	2,194	2,481	1,914
<b>% COAT recipients with 2 additional prescribers</b>	10.1%	13.1%	11.8%