

# Opioid Prescribing Improvement Program

Office of the MHCP Medical Director  
Health Care Administration

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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 Minnesotans 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:

- Provide a progress update on the Opioid Prescribing Work Group and the work completed to date;
- Provide key points from the draft Acute Pain Prescribing Recommendations, Post-Acute Pain Prescribing Recommendations, and Chronic Pain Prescribing Recommendations;
- Provide an update on the OPIP opioid prescribing measure development and MHCP Quality Improvement Program;
- Provide an update on the health care provider education campaign; and
- Provide a brief summary of how the OPIP complements other state agency initiatives to address opioid dependency and substance abuse.

The Department of Human Services (DHS) is committed to transforming prescribing practice via the transparent, and community-led focused structure of the OPIP. In the second year we focused on completing the opioid prescribing recommendations, analyzing opioid prescribing data within the Minnesota Health Care Program in order to develop clinically-useful measures, and selecting a vendor to assist with the prescriber education campaign. The focus of the work group for the remainder of calendar year 2017 is to provide final recommendations on the opioid prescribing measures, and components of the prescriber quality improvement program. Community participation is steady at the monthly OPWG work group meeting, and DHS provides opportunities for public comment on each of the OPIP components. All of this work moves us closer to reducing the number of residents who become new chronic opioid users, reducing the health care utilization costs associated with opioid dependency and substance abuse, and most important, reducing the devastation in Minnesota communities related to opioid dependency and addiction.

## II. Legislation

Minnesota Statutes 2015, section 256B.0638, subdivision 7; MINN. STAT. 256B.0638 (2015);

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 continues to be a significant public health concern in Minnesota. Drug overdose deaths in Minnesota increased 11 percent from 2014 to 2015. Of the 572 total drug overdose deaths, 216 residents died from an overdose related to prescription opioid analgesics, and 115 died from a heroin overdose.<sup>1</sup> Preliminary analysis of 2016 drug overdose death data indicates that the number of deaths has increased.

The increase in opioid-related overdose deaths over the last decade is related to the significant increase in opioid prescribing over the same period. Sales of prescription opioids in the U.S. nearly quadrupled from 1999 to 2014. In 2012, providers wrote 259 million opioid prescriptions – enough for every American to have their own bottle of pills.<sup>2</sup> The role of prescribers in the current epidemic of opioid use has become a key focus of prevention efforts. In 2016, the Centers for Disease Control and Prevention (CDC) issued the first set of national opioid prescribing recommendations for chronic pain conditions.

Increased attention to prescribing behaviors from government entities, professional associations and other stakeholders appears to be having a positive effect on prescribing. Nationally, the 2016 opioid prescribing rates were the lowest recorded in the last 10 years. However, the rates remain significantly higher than they were prior to the onset of this public health crisis, and significant variation in prescribing rates occurs at the national, state, local and provider levels. The prescribing rate was 46.9 prescriptions for every 100 Minnesotans in 2016.<sup>3</sup> However, within the state, there are several counties in which the rate of prescribing is high enough or nearly high enough for each person to receive a prescription.

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)—dependency and substance abuse that are related to the prescribing of opioid analgesics by health care 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 OPWG convened in November 2015 for a two-year commitment to perform its legislatively set tasks:

- Recommending protocols that address all phases of the opioid prescribing cycle (acute, post-acute, and chronic pain)
- Overseeing 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. Injury and Violence Prevention Unit. Drug overdose deaths among Minnesota residents: 2000-2015. Available at: <http://www.health.state.mn.us/divs/healthimprovement/data/reports/drugoverdose.html> . Accessed July 10, 2016.

<sup>2</sup> Center for Disease Control and Prevention. Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines — United States, 2012. MMWR 2014; 63(26);563-568.

<sup>3</sup> Center for Disease Control and Prevention. Opioid Overdose, U.S. Prescribing Maps. Available at: <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html>. Accessed August 15, 2017

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

Pursuant to the authorizing statute, the opioid prescribing protocols will not apply to opioids prescribed for patients who are experiencing pain caused by a malignant condition or who are receiving hospice care, or to opioids prescribed as medication-assisted treatment (MAT) to treat opioid dependency and opioid use disorder.

While the OPWG carries out its legislative set work, DHS staff will develop a reporting mechanism for quality improvement data pertaining to the OPIP. Limited funding is available for protocol development support, refining quality improvement measures and developing educational messages.

The OPIP is a unique community supported effort to improve prescriber practice via a community wide improvement process tied to Medicaid provider enrollment. The OPIP aims to balance the evidence for the use of opioids to treat pain with the inherent risks that these medications pose to individuals and communities.

#### **IV. Opioid Prescribing Work Group Progress Update**

The Department of Human Services, in collaboration with the Department of Health, convened the Opioid Prescribing Work Group (OPWG) in November 2015, with representation as stipulated in the legislation (Appendix A lists the OPWG membership, including the statutorily set membership categories of the OPWG). The OPWG met monthly throughout 2017.

**The OPWG completed discussion of the opioid prescribing protocols in spring 2017, and is currently developing the opioid prescribing measures. The OPWG is on schedule to complete these tasks by the end of 2017.** Completion of the opioid prescribing protocols concluded in spring 2017. Work group members conducted an extensive review of existing chronic pain opioid prescribing guidelines, and thoroughly discussed the complexity of chronic pain opioid prescribing. Upon review of the existing prescribing protocols, the OPWG members determined it was not sufficient to simply endorse one of the other guidelines. While the OPWG recommendations are consistent with the CDC chronic pain prescribing guidelines and the Institute for Clinical Systems Improvement (ICSI) opioid prescribing recommendations, the OPWG recommendations provide additional guidance. DHS staff are currently synthesizing the prescribing recommendations into a complete guidance, and will submit them to the Commissioner for approval in September. Highlights from the prescribing guidelines are included in this report.

Work group members recommended opioid prescribing measurement domains for each of the pain prescribing intervals in order for DHS to initiate development of the opioid prescribing sentinel measures. The OPIP uses the term “sentinel measure” to signal the need for an immediate response to opioid prescribing patterns that exceed the community agreed-upon standards. The recommended domains are included in this report, and are concordant with the prescribing guidelines. The work group is currently finalizing the measure specifications and is on track to be completed by the end of 2017.

Two work group members completed their terms of service in spring 2017. The commissioner appointed two new members—Bradley Johnson, MD (health plan medical director) and Detective Charles Strack (law enforcement representative) in summer 2017. The new appointments were made in a timely manner, per the Secretary of State’s competitive, open appointment process.

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’s web page is [www.mn.gov/dhs/opwg](http://www.mn.gov/dhs/opwg). DHS staff maintain a dedicated email address for communications pertaining to the OPWG: [dhs.opioid@state.mn.us](mailto:dhs.opioid@state.mn.us). Community members may 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.



## A. Opioid Prescribing Protocols

As noted above, the OPWG completed discussion of the prescribing protocols for acute pain, post-acute pain and chronic pain in spring 2017. The recommendations will be finalized once DHS staff synthesizes the three separate documents and the commissioner approves the complete guidance.

The protocols provide recommendations for clinicians who are prescribing opioids for acute pain, post-acute pain, and chronic pain, outside of active cancer treatment, hospice care, and end of life care. Although the primary intended audience of the recommendations are primary care clinicians, the recommendations also address opioid prescribing in acute care settings, and following dental and surgical procedures.

As was stated in last year's report, the acute pain prescribing recommendations were completed in summer 2016. The OPWG completed the draft post-acute pain prescribing recommendations in February 2017. DHS held a public comment period in March 2017, and received comments from 7 entities. Additionally, DHS staff presented the recommendations to the Minnesota Medical Association's (MMA) Prescription Opioid Management Advisory Task Force in February 2017. The work group reviewed all of the comments, and revised portions of the recommendations.

There are three key principals underlying the opioid prescribing recommendations. They include:

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 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.
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 opioid medications.

### **Key Clinical Points from the Opioid Prescribing Recommendations**

#### *Acute Pain (0 – 4 days following an acute event)*

- Avoid prescribing more than a three day supply or 20 pills of low-dose, short-acting opioids. Limit the entire prescription to 100 morphine milligram equivalents (MME)(not 100 MME per day).

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- 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 7 days or up to 200 MME, unless circumstances clearly warrant additional opioid therapy, such as extensive knee surgery or a crush injury. Limit the entire prescription to 200 MME (not 200 MME per day).
- Check the Prescription Monitoring Program (PMP) to review the patient's prescribing history whenever prescribing an opioid for acute pain.

### *Post-Acute Pain Prescribing Interval (5 – 45 days following an acute event)*

- 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.<sup>4</sup> Refer to the Acute and Post-Acute Pain Prescribing and Assessment Guide for the recommended risk assessment screenings prior to prescribing additional opioids (See Appendix B).
- 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. (Clinicians should adjust duration as needed so that the prescription does not run out on a weekend or holiday.) Prescribing should be consistent with expected tissue healing. Plan for expected tapering early in this treatment period.
- Develop a referral network for mental health, substance use disorder, pain education, and pain medicine.

### *Chronic Pain Prescribing Interval (46+ days following an acute event)*

The OPWG strongly recommends against initiating or using chronic opioid therapy for chronic pain. The evidence supporting the efficacy of chronic opioid therapy for chronic pain is insufficient, and the evidence for harm is clear. Yet, the OPWG also acknowledges that given the current chronic pain management environment and the concern that individuals may turn to illicit forms of opioids if chronic opioid therapy is improperly reduced or ceased, it is prudent to provide opioid prescribing recommendations that stress patient safety and harm reduction.

- Prescribe opioids at the lowest dose, with a recommendation of no more than 50 MME/day. Clinicians who decide to increase daily dosage above 50 MME/day should avoid exceeding 90 MME/day. Clinicians who decide to increase daily dose to 90 MME/day must carefully document that the risks and benefits associated with the dose increase were weighed, and the benefits warrant the risk.

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<sup>4</sup> Pain catastrophizing is an exaggerated negative mental set brought to bear during actual or anticipated painful experiences. There are three dimensions of catastrophizing: rumination; magnification; and helplessness. See Sullivan MJ. The Pain Catastrophizing Scale; User Manual. 2009. Available at: [http://sullivan-painresearch.mcgill.ca/pdf/pcs/PCSMannual\\_English.pdf](http://sullivan-painresearch.mcgill.ca/pdf/pcs/PCSMannual_English.pdf)

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- Limit the duration of the prescription to one month, and prescribe in multiples of 7 days so that the supply does not end on a weekend or holiday. Face to face visits with the prescribing provider should occur at least every 3 months.
- 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 (at each face to face visit).
- Implement risk mitigation strategies when initiating chronic opioid analgesic therapy (COAT), and continue through the duration of therapy. Strategies and frequency should be commensurate with risk factors and include: 1) Ongoing urine drug screening; 2) Pill count call backs; 3) Query the PMP; 4) Monitoring for overdose potential and for the presence of Opioid Use Disorder; 4) Making naloxone available to patients at risk for adverse outcomes; and 6) Offer or arrange evidence-based treatment for patients with OUD.

### B. Opioid Sentinel Measure Development

The OPWG recommended specific measurement domains to DHS for the opioid sentinel measures. These measures will be reported to prescribing providers via a peer review protected process, and will not contain client-identifiable data. Data will be confidentially shared with prescribers, and will remain confidential until the time a provider is disenrolled from the program. The OPWG is currently refining the opioid sentinel measures. Reports to the legislature in future years will contain complete baseline and progress data gathered with the final, recommended measures. A description of the measurement domains is provided below.

- The acute pain prescribing measure(s) will be based on the **frequency** and **amount** of opioids prescribed. The work group is currently discussing a measure of the frequency with which a provider exceeds the dose and duration recommendation in the OPWG acute pain prescribing protocol (100 MME or 200 MME for the initial opioid prescription).
- The post-acute pain prescribing measure will be based on a patient's **cumulative morphine exposure** during the post-acute pain period. Current evidence published by the CDC suggests specific benchmarks of opioid exposure that significantly increase the likelihood of progression to chronic opioid use. The OPWG and DHS propose to use a benchmark of 700 MME, which is consistent with the evidence.
- The chronic pain prescribing measures (3) will likely adhere closely to other chronic use measures in existence. The work group identified the following prescribing domains for measurement:
  - **Daily morphine equivalence dosage** (50 MME/day and 90 MME/day);
  - **Concurrent use of opioids and benzodiazepines**, or other opioid-combinations that significantly increase risk of opioid-related harm; and

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- **Patient adherence to chronic opioid prescriber.** This is measured by the number of prescribers from which a patient obtains an opioid prescription. Patients on COAT should receive prescriptions from a limited number of prescribers.

### *Data Analysis Findings*

DHS staff are currently analyzing prescribing data for MHCP-enrolled providers in order to support the opioid sentinel measure development. Preliminary data and staff analysis of the potential utility and pitfalls of the measures proposed by the OPWG are shared with the work group members as it works to refine its recommendations about measurement. The major findings from the data analysis conducted to date include:

- Overall opioid prescribing: In 2016, there were 691,516 opioid prescriptions written for MHCP enrollees (excluding patients with cancer and who receive hospice services)
- 146,984 or approximately 21% of those prescriptions were written for someone who was previously opioid naïve. Opioid naïve is defined as no opioid prescription claims within the past 90 days.
  - Of these individuals, an additional 66,547 prescriptions or approximately 10% of the total were written for acute and post-acute pain (up to 45 days following an acute event)
- 477,986 opioid prescriptions are written for individuals on chronic opioid therapy
- It is documented that the same counties with the highest overall rates of prescribing also are those with the highest rates of opioid use disorder. These communities are those in and around the tribal reservation.
- We have also found that the rate of new chronic use of prescribed opioids is over twice as high for those of American Indian heritage as for those of the rest of the population. Historical trauma, ongoing high poverty and associated social risks, and genetic factors converge to create the dynamics for this result.
- There is significant variation in opioid prescribing behaviors across provider specialty types, and within specialty types. See below.

### *Variation in Prescribing Behavior*

The work group is examining the variation in prescribing within provider groups by specialty. By ranking prescribers who wrote for opioids by the total amount of opioid they prescribed and then separating each specialty into quartiles, a wide variation in prescribing is noted. For initial opioid prescriptions written to previously opioid naïve enrollees, the prescribing rates between the lowest and highest quartile of prescribers varied by factors of 4 to 24 depending on specialty. For example, family practice providers in the top quartile prescribe approximately 10 times as

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much as the lowest quartile and 6 times as much as the median of the specialty. General surgeons in the top quartile prescribe approximately 15 times as much as the lowest quartile, and 3 times as much as the median of the specialty. The same amount of variation maintained and increased slightly across all specialty groups when the prescribing period was lengthened to 45 days, the post-acute period.

## **V. Minnesota Health Care Program Quality Improvement Program**

Pursuant to the legislation, DHS will create an opioid prescribing quality improvement program for MHCP-enrolled providers. MHCP-enrolled providers whose opioid prescribing exceed the thresholds to be determined by the OPWG will be required to submit quality improvement plans. The OPWG is currently discussing threshold recommendations in conjunction with the sentinel measure discussions. At this time it is expected that in the first year of reporting, prescribers will be alerted if they meet or exceed a recommended threshold. Required participation in the quality improvement program will begin in the second year of reporting prescribing data.

DHS is currently weighing options for the reporting mechanism. It is preferred to use an existing platform to support the reporting process, but the platform identified must be able to deliver the information to MHCP-enrolled providers under peer protected review. DHS will analyze the options, and begin development of the reporting mechanism by the end of fall 2017.

## **VI. Prescriber Education Campaign**

DHS has contracted with Weber Shandwick—a national communications firm with significant experience working with the Minnesota medical community—to develop educational resources for prescribers. Weber Shandwick will spend the next four months conducting research and focus groups with Minnesota health providers to inform a strategic marketing campaign. A portion of the Weber Shandwick work is funded through the DHS Alcohol and Drug Abuse Division’s State Targeted Response to the Opioid Crisis grant. Collaboration between DHS staff leads on the opioid prescribing campaign and the statewide opioid misuse and overdose prevention campaign provides consistency between messages. The target timeframe for the opioid prescriber campaign launch is December 2017/January 2018.

The Opioid Prescribing Improvement Program will begin focused communication about the prescribing recommendations and measurement work beginning in fall 2017. Members of the work group will present at a half-day CME session hosted by the Minnesota Medical Association, the Steve Rummeler Hope Network, and the University of Minnesota Medical School to discuss the OPIP and the Minnesota Opioid Prescribing Guidelines.

## **VII. State Agency Efforts to Address Opioid Dependency and Addiction**

Minnesota is facing the opioid crisis with multiple efforts and a high-level of coordination. Statewide efforts focus on moving as far upstream as possible, with the goal of decreasing excessive opioid prescribing, providing medications in our communities to treat overdoses, and improving access to treatment for those who have become addicted. Efforts over the past year are extensive.

State agencies collaborate on this work through the Minnesota State Substance Abuse Strategy (SASS). The SASS was developed in 2012 under the leadership of DHS, and in partnership with the departments of Education, Health, Public Safety, Corrections, Labor and Industry, the state judicial branch, and Minnesota Board of Pharmacy. The State Opioid Oversight Project (SOOP) coordinates the comprehensive interagency efforts.

### **State Opioid Oversight Project**

The State Opioid Oversight Project (SOOP) work group meets monthly and helps unify efforts from state agencies and prescribing boards to maximize their effectiveness. The SOOP mission is to develop a consensus-based plan to reduce the impact of opioid dependence among Minnesotans while appropriately managing pain; simultaneously move forward with more mature initiatives to reduce opioid dependence and its consequences. The SOOP will hold a strategic planning retreat in fall 2017. The emphasis of the strategic planning retreat will be: funding; framing the narrative around substance use disorder and addressing the opioid epidemic; and process and outcome measures for the eight SOOP focus areas.

The SOOP focuses on eight strategies that address multiple facets of the opioid crisis:

- Reducing Neonatal Abstinence Syndrome and improving maternal care through expanded treatment, services, and supports for pregnant women and substance-exposed infants;
- Improved access to medication-assisted treatment and recovery;
- Improve provider access to the Prescription Monitoring Program (PMP);
- Improved distribution of naloxone, the opioid overdose reversal agent;
- Primary prevention, focused on direct communications with prescribing providers when opioid prescriptions are first written and when prescriptions are continued;
- Improvement in opioid prescribing, through the OPIP; and
- Improved access to disposal for prescription opioids.
- Engagement with justice involved populations

### **Specific DHS efforts to address opioid dependency and addiction include:**

Below are some highlights of the DHS aspects of the state strategy. This is not a comprehensive review of all efforts.

- The Alcohol and Drug Abuse Division (ADAD) in coordination with the Office of the Medical Director have received a \$10.4 million grant to advance new models including



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expansion of prevention, improved office based treatment resources, and improved care of mothers with opioid use disorder.

- The Alcohol and Drug Abuse Division also received a 5-year grant to develop primary prevention resources in high-risk communities for opioid misuse and abuse. The grant focuses on individuals under the age of 17; raising community awareness and engaging schools, communities, parents, prescribers, and their patients.
- The Alcohol and Drug Abuse Division is implementing 2017 legislation to improve the continuum of substance use disorder treatment. This includes improvements in access to assessment, care coordination, and support for peer recovery specialists.
- The Health Care Administration's Integrated Care for High Risk Pregnant Women (ICHRP) grant program targets pregnant Medical Assistance enrollees residing in geographical areas identified as being above-average risk for prenatal opioid exposure.

## **VIII. 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, NCPS, Fond du Lac Human Services Pharmacy (pharmacist)
- Dana Farley, MS, Minnesota Department of Health (nonvoting)
- Rebekah Forrest, RN, CNP, Native American 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), Winona (consumer representative)
- Pete 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)
- Jeffrey Schiff, MD, MBA, Minnesota Department of Human Services (MHCP medical director; nonvoting)
- Detective Charles Strack, Little Falls Police Department (law enforcement)
- Lindsey Thomas, MD, Hennepin County Medical Examiner's Office (medical examiner)

## IX. Appendix B. OPIP Acute and Post-Acute Pain Prescribing and Assessment Guide

The purpose of this chart is to guide clinicians on the responsible prescribing of opioids through the acute and post-acute pain period. Complete the recommended assessments based on the pain phase prior to prescribing opioids. Total Morphine Milligram Equivalence (MME) Exposure is the cumulative morphine milligram equivalents for all outpatient opioid prescriptions written in the acute pain and post-acute pain prescribing interval. Avoid prescribing in excess of 700 MME (cumulative), in order to reduce the risk of chronic opioid use and other opioid-related harms. Guidance about how to use this chart is available on page two.

#	Pain Phase/Days Past Acute Event	Total MME Exposure	Nociceptive Pain	Tissue Healing Sufficient	Perceived pain & function match expected progress	Mental health <sup>a</sup>	Chemical dependency <sup>b</sup>	Chronicity risk assessment <sup>c</sup>	Reassess etiology of pain	Non-opioid pain management	Taper
1	Acute (0-4 days)	0 to 100 MME	Expected	No	Yes	No	No	No	No	Yes	No
2	Major acute (5- 14 days)	101 to 400 MME	Expected	No	Yes	No	No	No	No	Yes	No
3	Post-Acute (5-14 days)	101 to 400 MME	Not expected	Yes	No	Yes	Yes	No	Yes	Yes	Yes*
4	Post-Acute (After 14 days)	401 to 600 MME	Expected	No	Yes	Yes	No	No	No	Yes	No
5	Post-Acute (After 14 days)	401 to 600 MME	Not expected	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes*
6	Post-Acute (After 21 days)	601+ MME	Expected	No	Yes	Yes	Yes	Yes	No	Yes	Yes
7	Post-Acute (After 21 days)	601+ MME	Not expected	Yes	No	Yes	Yes	Yes <sup>d</sup>	Yes	Yes	Yes

<sup>a</sup> Validated tools for depression and anxiety include the PHQ-2, PHQ-9 or the GAD-7.

<sup>b</sup> Brief, validated screening tools or chemical dependency include the Quick Screen.

<sup>c</sup> Screening tools for fear avoidance behaviors and pain catastrophizing include the Keele's STarT Back, TSK-11, FABQ, and the Pain Catastrophizing Scale (PCS).

<sup>d</sup> Consider other risk factors for chronic pain and chronic opioid use such as Post-Traumatic Stress Disorder (PTSD), adverse childhood events, and sexual abuse.

\* Determine the need for a taper and the taper rate based on the patient's withdrawal symptomology, and dose and/or duration considerations

**How to Use this Chart: 2 Options**

1. Identify the number of days that have passed since the date of injury or procedure (acute event). Complete the assessments indicated in the corresponding row prior to prescribing opioids. The chart also indicates the expected cumulative MME exposure at that point in the pain phase, based on the OPWG dose and duration recommendations.

Example 1: A patient requests additional pain relief 16 days after a surgery. Ongoing nociceptive pain is not anticipated and the patient's pain experience does not match the tissue healing progress. The clinician provides the recommended risk assessments in Row 5. If the clinician determines that additional opioid analgesia is appropriate, then he or she should check the PMP. It is expected at this point that the cumulative MME exposure is under 600 MME.

2. Identify the recommended risk assessments to conduct prior to writing a prescription, based on the amount of MME prescribed or the time period that the prescription is intended to cover.

Example 2: A patient undergoes major orthopedic surgery. The clinician prescribes the patient 30 tablets of Oxycodone HCL/Acetaminophen (10 MG-325 MG). The total MME of the prescription is 450. Given the amount of MME prescribed, the clinician should perform the assessments indicated in Row 4 of the chart.