Agenda

• Welcome and introduction
• Presentations:
  – Minnesota: Mark Kinde
  – Michigan: Audra Putt
  – CDC’s National Center for Injury Prevention and Control: Dr. Jan Losby
• Q and A, Discussion
• Updates and Announcements
Speakers

Mark Kinde
Injury and Violence Prevention Section
Minnesota Department of Health

Audra Putt
Cancer Prevention and Control Section
Michigan Department of Health and Human Services

Dr. Jan Losby
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
“Public health is the constant redefinition of the unacceptable”

Geoffrey Vickers
“Public health is what we, as a society, do collectively to assure the conditions in which (all) people can be healthy.”

-Institute of Medicine (1988), *Future of Public Health*
Hospital-treatment for Alcohol and Opioids Working Age Adults (25-64 years)

Hospital-treated cases for alcohol- and opioid-related diagnoses, 25-64 year olds

- Alcohol-related conditions, including abuse or dependence
- Opioid poisoning, abuse, or dependence
- Heart attacks and stroke

Number of Hospital-treatments

Year

Opioid Overdose in Minnesota, 2017

- **395** Deaths
- **800** Inpatient Hospitalizations
- **1,451** Emergency Room Visits
- **2,958** EMS Responses
How do we do our work?
Making Prevention Happen

Targeted Programs  Driven by Data  Guided through Partnerships
Nonfatal Update: ED Data

Note: ED cases include only emergency room visits.
Note: This graph represents quarterly data not yearly totals.
Note: The all-opioid involved overdose category includes cases for heroin, opioid (excluding heroin), or both.
Data source: Minnesota Hospital Discharge Data, Minnesota Department of Health, Injury and Violence Prevention Section

Emergency room visits for opioid-involved overdoses steadily increased over past ten years

The grey area denotes the transition to ICD-10-CM. Trends in the data over this period should be interpreted cautiously.
Nonfatal Hospital-treated

Hospital-treated opioid overdoses have steadily increased over the past 10 years

The grey area denotes the transition to ICD-10-CM. Trends in the data over this period should be interpreted cautiously.

Note: Hospital Treated visits include emergency room visits and inpatient hospitalizations.
Note: This graph represents quarterly data not yearly totals.
Note: The all-opioid involved overdose category includes cases for heroin, opioid (excluding heroin), or both.
Data source: Minnesota Hospital Discharge Data, Minnesota Department of Health, Injury and Violence Prevention Section
Opioid Dashboard (a): How To Find It

Search "Opioid Dashboard"

from search engine (e.g., Google, Bing)

Or type URL:

www.health.state.mn.us/opioiddashboard
Opioid Dashboard (b): How to find it

Indicator Dashboards Opioid Dashboard
www.health.state.mn.us/divs/healthimprovement/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. If you have a ...

Death Reporting · Nonfatal Opioid Overdose · Pain Management · Naloxone
2017 Opioid-involved Overdose Deaths
2017 Drug Overdose Deaths: Drug Categories

Drug overdose deaths by non-exclusive drug category,
MN residents, STATEWIDE, 2000-2017

- All opioid-involved deaths (401)
- Other Opioids and Methadone (188)
- Synthetic Opioids (172)
- Psychostimulants (152)
- Heroin (106)
- Benzodiazepines (86)
- Cocaine (60)
2017 Drug Overdose Disparities

Disparities in drug overdose mortality rates have grown from 2010 to 2017

- American Indian: 70.0
- African American: 27.4
- White: 11.4
Thank you!

Mary Manning, RD, MBA & Mark Kinde, MPH
HPCD / IVPS
Minnesota Department of Health

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Collaborative Approaches in Michigan to Address Opioids and Chronic Disease Pain

AUDRA PUTT, PALLIATIVE CARE CONSULTANT
CANCER PREVENTION AND CONTROL SECTION
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Overdose Prevention in States (OPIS)

CDC Prevention for States (PfS) Grant
Announced in 2015
Awarded to 16 states

CDC Data-Driven Prevention Initiative (DDPI) Grant
Announced in 2016
Awarded to 13 states (including Michigan)
MDHHS PDO Prevention Program
Stakeholder Work Groups

- Improved prescribing practices
  - Outreach Group A
  - Outreach Group B

- Enhanced opioid surveillance
  - Surveillance Group
Outreach Work Group B

Increase provider uptake of evidence based guidelines, such as the CDC Prescribing Guideline, by increasing access to education, training and outreach opportunities.
GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS
- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient
Michigan Cancer Plan Objective:
Decrease the percent of MI adults diagnosed with cancer who report physical pain due to cancer treatment.

Michigan Cancer Consortium (MCC) Workgroup Project:
Create a shared decision-making document for survivors that provides education on physical pain management and various methods of pain control related to cancer treatment.

- Include questions patients can ask providers about pain management.
- Meet accessibility guidelines.
Focus groups were held with survivors to learn about the types of information they find valuable to include in a shared decision-making document.

Two focus groups were held (one rural, one urban).

Participants were asked:
1) What are some helpful topics or information that should be included in a shared decision-making document?
2) Please provide input on how a shared decision-making document of this type should be formatted:
Survivor Focus Group Feedback

Common Themes for Both Groups
- Support for use of alternative therapies
- Expectations around pain post-treatment and how it will continue to impact daily life
- Survivors want to be included in the decision-making process
- Pain manifests in different ways

Document Design for Both Groups
- Shorter is better (pamphlet, small booklet)
- Include photos and graphics- “bright and cheery”
- Bullet points
- Inclusion of references & resources
- Questions to ask providers
- Space for notes
The document will be drafted throughout spring 2019.

Focus groups will be held again in early fall to review the document for usability and readability.

A promotion plan for the document will be created.
Contact Information

Audra Putt, Palliative Care Consultant
PuttA@michigan.gov
Opioid Overdose Epidemic: CDC Response

Jan Losby, PhD, MSW
Team Lead, Health Systems
Division of Unintentional Injury Prevention, CDC

NACDD Webinar
May 2, 2019
Nearly 400,000 people have died from an opioid overdose since 1999.

Three Waves of the Rise in Opioid Overdose Deaths

Wave 1: Rise in Prescription Opioid Overdose Deaths
Wave 2: Rise in Heroin Overdose Deaths
Wave 3: Rise in Synthetic Opioid Overdose Deaths

Rapid Increase in Drug Overdose Death Rates by County

SOURCE: NCHS Data Visualization Gallery
Conduct surveillance and research

Empower consumers to make safe choices

Build state, local, and tribal capacity

Support providers, health systems, and payers

Partner with public safety

CDC’s Approach: Opioid Overdose Prevention
CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

- Primary care
- Patients > 18 Years with chronic pain
- Outpatient settings
- Outside of active cancer, palliative, and end of life care
Organization of Guideline Recommendations

12 recommendations grouped into 3 conceptual areas:

- Determining when to initiate or continue opioids for chronic pain
- Opioid selection, dosage, duration, follow-up, and discontinuation
- Assessing risk and addressing harms of opioid use
Comprehensive Implementation Approach for the CDC Prescribing Guideline

Translation & Communication

Education & Training

Insurer Interventions

Health System Interventions
Translation & Communication

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

**CHECKLIST**

When CONSIDERING long-term opioid therapy
- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (eg, addiction, overdose) with patient.

When REASSESSING at return visit
- Assess pain and function (eg, PEG); compare results to baseline.
- Evaluate risk of harm or misuse:
  - Observe patient for signs of over sedation or overdose risk.
  - If yes: taper dose.
  - Check POME:
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
- If yes: refer for treatment.
- Check that non-opioid therapies optimized.
- Determine whether to continue, adjust, taper, or stop opioids.
- Calculate opioid dosage morphine milligram equivalent (MME):
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow up; consider offering naloxone,
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider opioid referral.
- Schedule reassessment at regular intervals (≤3 months).

POCKET GUIDE: TAPERING OPIOIDS FOR CHRONIC PAIN

Follow up regularly with patients to determine whether opioids are meeting treatment goals and whether opioids can be reduced to lower dosage or discontinued.

APP includes:
- MME Calculator
- Prescribing Guidance
- Motivational Interviewing
Education & Training

Online training modules & webinars for clinicians (earn CE/CME credits)

Interactive Trainings:
1. Addressing the Opioid Epidemic: Recommendations from CDC
2. Treating Chronic Pain Without Opioids
3. Communicating with Patients
4. Reducing the Risk of Opioids
5. Assessing and Addressing Opioid Use Disorder
7. Determining Whether to Initiate Opioids for Chronic Pain
8. Implementing CDC’s Prescribing Guideline into Clinical Practice
9. Opioid Use and Pregnancy
10. Motivational Interviewing
11. Collaborative Patient-Provider Relationship in Opioid Clinical Decision Making

To learn more:
www.cdc.gov/drugoverdose/training/index.html

Clinical Outreach and Communication Activity (COCA) Free Webinars
1. Overview of Guideline
2. Nonopioid Treatments for Chronic Pain
3. Assessing Benefits and Harms of Opioid Therapy
4. Dosing and Titration of Opioids
5. Opioid Use Disorder—Assessment and Referral
6. Risk Mitigation Strategies
7. Effective Communication with Patients

To learn more:
emergency.cdc.gov/coca/calls/2016/index.asp
**Insurer Interventions**

1. Cover evidence-based non-pharmacologic therapies like exercise and cognitive behavioral therapy
2. Make it easier to prescribe non-opioid pain medications
3. Reimburse patient counseling, care coordination, and checking PDMP
4. Promote more judicious use of high dosages of opioids using drug utilization review and prior authorization
5. Remove barriers to evidence-based treatment of opioid use disorder
Health Systems Interventions

- Clinical decision support (CDS) tools embedded in electronic health records (EHRs)
- EHR and PDMP (prescription drug monitoring program) Integration
- Clinical Quality Improvement and Care Coordination
Encourage careful and selective use of opioid therapy and to facilitate actual implementation of the CDC Guideline for Prescribing Opioids for Chronic Pain.

Help health systems and primary care providers integrate quality improvement (QI) measures into their clinical practice.
### QI Measure Description

#### New Opioid Prescription Measures

1. The percentage of patients with a new opioid prescription for an immediate-release opioid.

2. The percentage of patients with a new opioid prescription for chronic pain with documentation that a PDMP was checked prior to prescribing.

3. The percentage of patients with a new opioid prescription for chronic pain with documentation that a urine drug test was performed prior to prescribing.

4. The percentage of patients with a follow-up visit within four weeks of starting an opioid for chronic pain.

5. The percentage of patients with a new opioid prescription for acute pain for a three days' supply or less.

#### Long-term Opioid Therapy Measures

6. The percentage of patients on long-term opioid therapy who are taking 50 MMEs or more per day.

7. The percentage of patients on long-term opioid therapy who are taking 90 MMEs or more per day.

8. The percentage of patients on long-term opioid therapy who received a prescription for a benzodiazepine.

9. The percentage of patients on long-term opioid therapy who had a follow-up visit at least quarterly.

10. The percentage of patients on long-term opioid therapy who had at least quarterly pain and functional assessments.

11. The percentage of patients on long-term opioid therapy who had documentation that a PDMP was checked at least quarterly.

12. The percentage of patients on long-term opioid therapy who the clinician counseled on the risks and benefits of opioids at least annually.

13. The percentage of patients on long-term opioid therapy with documentation that a urine drug test was performed at least annually.

14. The percentage of patients with chronic pain who had at least one referral or visit for nonpharmacologic therapy as a treatment for pain.

15. The percentage of patients on long-term opioid therapy who were counseled on the purpose and use of naloxone, and either prescribed or referred to obtain naloxone.

16. The percentage of patients with an opioid use disorder (OUD) who were referred to or prescribed medication-assisted treatment (MAT).
5 Steps for Implementing an Opioid QI Effort in a Healthcare System or Practice

**Step 1** Obtain Leadership Support and Identify a Champion(s)

**Step 2** Assess Current Approach to Opioids and Identify Areas for Improvement

**Step 3** Select and Prioritize Guideline Recommendations to Implement

**Step 4** Define System Goals

**Step 5** Develop a Plan, Implement, and Monitor Progress
Practice Level Strategies for Care Coordination

This chapter provides practical guidance for specific strategies to improve the coordination of long-term opioid therapy at the healthcare system and practice level.

1. **Use an Interdisciplinary Team-based Approach:**
   Using a team-based approach across multiple disciplines and specialties improves the management and coordination of care.

2. **Establish Opioid Policies and Standards:**
   Develop and implement practice-wide policies or standards to support and encourage consistent long-term opioid therapy management and coordination.

3. **Use EHR Data to Develop Patient Registries and Track QI Measures:**
   EHRs are critical sources of information for managing and monitoring implementation by care teams and registries are useful to identify patients to target for specific interventions and care coordination.
State Programs
Overdose Prevention in States Initiative

NOTE: All states receive OPIS $5 fund except Hawaii

Select Components

- Surveillance
- Planning
- PDMPs
- Evaluate Policy
- Linkage to Care
- Health System
- Local Response
Evidence-Based Strategies for Preventing Opioid Overdose: What’s Working in the United States

- Consolidates best evidence currently available on 10 opioid overdose prevention strategies
- Topics span:
  - naloxone distribution
  - medication-assisted treatment
  - clinical programs
  - community programs
- Offers relevant research and examples of effective strategies being used in the US

Clinical Decision Support resources:
- Implementation guide output:
  http://build.fhir.org/ig/cqframework/opioid-cds/
- Source for the implementation guide:
  https://github.com/cqframework/opioid-cds
- Supporting Java packages for the CQL-to-ELM translator and CQL Engine:
  https://github.com/cqframework/opioid-cds-logic

Resources for patients:
https://www.cdc.gov/drugoverdose/patients/index.html
https://www.cdc.gov/rxawareness/index.html

Resources for providers:
https://www.cdc.gov/drugoverdose/providers/index.html

QI and Care Coordination resources:
https://www.cdc.gov/drugoverdose/prescribing/qi-cc.html
The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Contact:
Jan Losby
JLosby@cdc.gov

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Question + Answer

Discussion
Updates and Announcements
NACDD Updates

Regional Network calls
- Q2 Regional Network Calls are occurring April 29 – May 13, 2019
- Calendar invites have gone out for those calls with agendas
- Contact is Amanda Martinez, amartinez@chronicdisease.org

Strategic Leadership in Public Health State Agencies
- NEW online cohort course for emerging leaders
- Overview of strategic leadership with an emphasis on systems change within the context of the public health state agency
- Course Dates: May 20 – June 28 (six weeks)
- Send nominations to akaravanov@chronicdisease.org by May 17
NACDD Updates

Chronic Disease Prevention Leadership Meetings (CDPLM):
- September 9-11 and October 21-23
- Contact Abby Lowe-Wilson at alwilson@chronicdisease.org to get on the list for one of these meetings

2019 GEAR Groups for Mid-Level Chronic Disease Practitioners - Groups on each of the following topics:
- Housing Access
- Education and Health
- Leading with Race
- Preventing Adverse Childhood Experiences
- Building Inclusive Communities
- Contact Julie Dudley jdudley@chronicdisease.org
New Chronic Disease Directors Orientation

- For new CDDs/those in the position less than 2 years
- Starts end of May
- Monthly videoconference meetings for four months
- Between meetings, participants engage in online discussions, complete readings, and listen to recorded presentations
- Contact Tamara Engel for more info tengel@chronicdisease.org
Regional Representatives Committee

Region A:
Julie Arel, Vermont

Region B:
Jessica Wright, West Virginia

Region C:
Ginie Daguise, South Carolina

Region D:
Sue Thomas-Cox, Kentucky

Region E:
Linda Scarpetta, Michigan

Region F:
Melissa Martin, Louisiana

Region G:
Ryan Lester, Kansas

Region H:
Laurie Schneider, Colorado

Region I:
Lola Irvin, California

Region J:
Pama Joyner, Washington
Next First Thursday Webinar
Thursday, June 6, 3-4 pm EST

Applying Performance Management Practices to Strategic Plan Implementation: An example from Colorado's Prevention Services Division