Measure 2 Overview: Percent of index opioid prescriptions that exceed a reference dose (surgical)

Numerator: The number of index opioid prescriptions prescribed in the measurement year that exceeded the recommended dose (200 morphine milligram equivalence (MME))
Denominator: The number of index opioid prescriptions prescribed in the measurement year.

Key understandings:

- Total MME is the **MME of the total prescription**, for example, the whole bottle (not daily MME).
- An index opioid prescription is the **first prescription provided** to an opioid naïve patient.
- An opioid naïve patient is **someone without an active opioid prescription for 90 days before** the date of the prescription. Patients counted in this measure had to have been enrolled in Medicaid for 3 months before the first prescription. **It cannot be someone new to Medicaid.**
- DHS set the reference dose at 200 total MME, but **supports patient-centered, procedure-specific dosing** whether it is higher or lower than the DHS reference dose.

Why is it important to measure this prescribing behavior?

- The odds for long-term use may be greater with higher dose and duration of initial opioid exposure. This is especially important to monitor in post-operative prescribing, when patients may transition between prescribers and/or facilities.[i]
- A growing body of resources provide post-operative, procedure-specific opioid prescribing guidance. Surgeons across Minnesota helped developed patient-centered, procedure-specific benchmarks that take in to account varying needs of pain management for different procedures.[ii]

Community standards for treating acute pain

- Use scheduled acetaminophen and/or NSAIDs unless contraindicated
- Use the lowest strength, short-acting dose for the shortest duration in the initial opioid prescription
- Provide patient with follow-up instructions if the pain does not resolve as expected
- **Additional considerations for postoperative pain:**
    - Use the benchmark MME for patient-centered procedure-specific opioid dosing
    - Communicate plans during transitions to other facilities and across prescriber transitions, for example, rehabilitation

Universal standards of care for any pain phase

- Communicate realistic expectations about anticipated pain
- Conduct a risk assessment
- Weigh risks vs. benefits
- Educate about opioid risks, safe use and disposal
- Check the Prescription Monitoring Program
- Offer Naloxone for patients at risk of overdose
- Avoid "PRN" instructions, clearly explain how to take and stop using opioids

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[i] Chou R, Wagner J, Ahmed A, et al. Treatments for Acute Pain: A Systematic Review. Comparative Effectiveness Review No, 240. AHRQ Publication No. 20(21)-EHC006. December 2020
[ii] Hansen A, Neely C, Dvorkin J, Hadzic S. ICSI Adult Opioid Postoperative Prescribing Toolkit. ICSI. Minneapolis, Minnesota. 2020. (Available at www.icsi.org)