Measure 5 Overview: Percent of patients on chronic opioid analgesic therapy exceeding 90 morphine milligram equivalents (MME) per day (high-dose chronic opioid analgesic therapy)

Numerator: the number of patients on chronic opioid analgesic therapy with the daily dose exceeding 90 MME per day during the measurement year.
Denominator: the number of patients with an opioid prescription during a period on COAT in the measurement year.

Measure 5 key understandings:

- DHS defines chronic opioid analgesic therapy (COAT) as 60 or more consecutive days on opioid therapy. A patient is **counted in the numerator when the prescription is at least a 28-day supply.**
- Patients receiving opioid therapy from multiple providers may be counted in each prescriber's numerator.
- The goal of measuring this prescribing pattern is NOT to encourage clinicians to reduce patients' dosage under 90 MME per day. The daily dosage is used as an indicator to determine whether prescribing COAT is a core tenant of your practice, and if so, to learn what processes are in place to manage patient safety.
- DHS recognizes that the consolidation of patients with chronic pain among health systems and clinics means that certain providers manage a large panel of chronic pain patients.

What is it important to measure this prescribing behavior?

- Evidence indicates that opioid-related benefits in pain or function plateau above 50 MME per day, but opioid-related risk progressively increases as dosages increase.[i,ii]
- Opioid dosages for chronic pain of 50 to less than 100 MME per day in observational studies have been associated with increased risks for opioid overdose by factors of 1.9 to 4.6 compared with dosages of 1 - ,20 MME per day, and dosages greater than or equal to 100 MME per day with increased risks of overdose 2.0 – 8.9 times the risk at 1 to less than 20 MME per day.[iii,iv,v]
- If greater than 10 percent of your Medicaid-enrolled patients receive daily doses greater than 90 MME, it is important that you have the support and resources required to manage high-risk, chronic pain patients.

Standards of care for treating chronic pain

- DO NOT ABRUPTLY STOP OPIOIDS without a clear plan
- Avoid initiating opioids for chronic pain
- Avoid prescribing opioids and benzodiazepines together
- Increase intensity of management commensurate with risks or comorbidities
- Limit the number of prescribers
- Screen for Red Flags for Opioid Use Disorder (OUD) more frequently and provide immediate referral for intervention or treatment if needed
    - Red Flags of OUD: Signs of impaired control; signs of social impairment; risky use of opioids; predisposition to addiction; multiple prescribers; signs of tolerance or withdrawal
- Regularly offer and discuss tapering options with patients
- Use chronic condition management tools and care plans to support patients
- Conduct routine case reviews

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[i] Coyle DT, Pratt CY, Ocran-Appiah J, et al. Opioid analgesic dose and the risk of misuse, overdose and death: A narrative review. *Pharmacoepidemiology and drug safety* 2018; 27(5): 464-472

[ii] Chou R, Hartung D, Turner J, et al. Opioid treatments for chronic pain, Comparative effectiveness review no. 229. *AHRQ publication no. 20-EHC011.* April 2020

[iii] Bohnert ASB, Valenstein M, Bair MJ, et al. Association between opioid prescribing patterns and opioid overdose-related deaths. *JAMA* 2011; 305(13): 1315-1321.

[iv] Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med* 2010; 152(2): 85-92.

[v] Gomes T, Mamdani MM, Dhalla IA, et al. *Opioid dose and drug-related mortality in patients with nonmalignant pain.* Arch Intern Med 2011; 171(7): 686-691.