Measure 3 Overview: Percent of opioid prescriptions that met or exceeded 700 cumulate MME in the post-acute pain phase

The numerator: The number of prescriptions prescribed during the post-acute pain period that met or exceeded the 700 cumulative morphine milligram equivalence (MME) threshold in the measurement year.
The denominator: The number of opioid prescriptions prescribed during the post-acute pain period in the measurement year.

Key understandings:

- This measure is about understanding a **patient's risk of chronicity.**
- This measure **includes the index opioid prescription and any other opioids prescribed within a 45-day window of the date** of the index opioid prescription.
- Patients included in this measure **were opioid naïve before the index opioid prescription**. An opioid naïve patient is someone without an active opioid prescription for 90 days before the index opioid.
- Cumulative MME means that the total MME of each prescriptions is added together.
- The **clinician who writes the prescription that takes the patient to or over 700 cumulative MME** exposure in 45 days has that patient counted in their numerator.

Why is it important to understand this prescribing behavior?

- Preventing the transition to long-term use among patients who received opioids for acute pain is important in reducing future opioid-related morbidity and mortality.
- Exposure to 700 cumulative MME over the course of six weeks among opioid naïve patients is a risk factor for long-term use.[1] Other red flags for chronicity: second prescription or refill; initial 10-30 day supply; long-acting opioids; tramadol; drug use disorder; mental health diagnosis; or opioid prescription before age 18.

Standards of care for treating post-acute or episodic pain

- Assess for risk of transition to chronic use, or risk of harm
- Assess for biopsychosocial concerns influencing pain
- Verify patient understanding of how to use opioids
- Limit number of prescribers where possible
- Reduce quantity of the prescribed refill
- Communicate plans across prescriber transitions
- Avoid prescribing over 700 cumulative MME

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 Drug Monitoring Program
- Use lowest strength, short-acting dose for shortest duration
- Offer Naloxone for patients at risk of overdose
- Avoid "PRN" instructions, clearly explain how to take and stop using opioids

[1] Shah A, Hayes CJ and Martin BC. Characteristics of initial prescription episodes and likelihood of long-term opioid use – United States, 20016-2015. 2017 *MMWR Morb Mortal Wkly Rep*; 66(10): 265-269.