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Opioid Acute Non-Surgical Prescribing
July 2018

Introduction

The opioid working group charge was to recommend community prescribing standards for first opioid prescriptions in ambulatory settings including urgent care, emergency rooms, and dentistry. The goal is to decrease the quantity of opioids that are prescribed. Our recommendations are not intended for patients who are receiving palliative care for serious advanced illness or end-of-life care such as hospice.

Evidence has not demonstrated that opioids are either safe or effective. In fact, there is no safe dose of opioids (Bonnie, 2017). Long-term opioid use often begins with treatment of acute pain (Edlund, 2014). Prescribers should first consider all non-opioid options to relieve pain, communicate realistic expectations with patients, and engage them in creating shared treatment goals.

When further treatment is required, and the short-term use of opioids is considered for objective major tissue injury or damage, prescribers and patients need to carefully weigh the benefits against the risks of short-term opioid use, such as side-effects and complications, including overdose and addiction.

Recent studies now identify prescribing practices which may contribute to long-term opioid use and increase the risk of opioid use disorder. The likelihood of chronic opioid use increases with each additional day of opioid supplied beyond the third day, a second opioid prescription or refill, 700 morphine milligram equivalents (MME) or higher cumulative dose, patients started on a long-acting opioid and tramadol, and an initial 10 or 30-day supply (Shah, 2017).

Call to Action

Organizations should urgently support efforts to decrease opioid prescriptions.

- Most patients will not require an opioid, so we ask you to consider individual patient needs in every instance.
- We ask you to systematically aim towards reducing the quantity of opioids to below the maximum of 100 MME for the initial acute non-surgical prescription.
- It is recommended that each ambulatory department use these recommendations to reduce both the rate of new prescriptions and the quantity of opioids dispensed.
- Use internal and Collaborative data to understand how your acute non-surgical opioid prescriptions compare to other departments and other organizations.
- Monitor outcomes (changes in prescribing patterns) and potential unintended consequences.

Recommendations

- Patients or family members should be educated about available non-opioid options, how to safely use opioids if prescribed, and the safe disposal of unused opioids.
- Pain treatment should start with non-opioid therapies (e.g. NSAIDs, acetaminophen) whenever possible, shared treatment goals, realistic expectations of pain, and a thorough assessment. All patients require a review of current medications with consideration for risk of exceeding daily MME and excessive acetaminophen doses.
- When further treatment is required, and the use of opioids is considered, prescribers and patients need to carefully weigh the benefits against the risks of short-term use, such as side effects and complications, including overdose and addiction.
- Clinicians should consider querying the Prescription Drug Monitoring Program before prescribing opioids.
- When opioid analgesics are indicated for acute pain with objective major tissue injury or damage in the ambulatory setting (e.g., ED, UC, clinic, dental), the prescriber should use the lowest strength, short-acting opioid for the shortest period of time.
- Opioid doses should be individualized based on risk for adverse outcomes and response to treatment, especially in medically complex patients.
- The first opioid prescription for acute pain should be the lowest possible effective strength of a short acting opioid, not to exceed 100 MME total dispensed. Patients should be instructed that three days or less will often be sufficient.

Special Populations:

Patients already on chronic opioids:

For patients presenting in acute pain, already on chronic opioids, opioid tolerant or on methadone:

- Continue their current opioid and consider prescribing an additional 100 MME maximum short-acting opioid for this acute episode
- Create a plan to return the patient to their baseline dose as soon as possible

Geriatric Patients:

Geriatric patients should be assessed for risk of falls, cognitive decline, respiratory malfunction, and renal malfunction before receiving opioids.

- If impairment or risk is detected in a geriatric patient, consider reducing the initial opioid dose by at least 50%.

Pediatric and Adolescent Patients:

Opioids should be cautiously used in children. The developmental elements of pain systems, the differences in pharmacokinetics and pharmacodynamics in young children make use of these medications more complex. Infants younger than 6 months are less able to metabolize opioids. The following recommendations refer to opioid use for acute pain:

- Pediatric dosing is based on mg or mcg/ kg, not to exceed the adult dose.
- Pediatric dosing is not based on age.
- For obese children (>30 BMI) use the lean or normal weight for calculation.
- Be aware of total acetaminophen dose when using combination medications.

Implementation Process Tips

- Elevate clinician, staff and patient awareness of the nature of pain and available treatments, the risk of opioids and their proper disposal (Hooten, 2017, Disposal CTA)
- Verify that your imbedded EHR workflows support Collaborative recommendations (alerts, order sets, preferences, existing protocols/ guidelines, decision-support tools, etc.)
- Setting default opioid quantities in the EHR may discourage thoughtful prescribing for each patient. Evidence shows that patients may be over or under treated using default quantities (Santistevan, 2017).
- Fully implement electronic prescribing for controlled substances
- Facilitate calculation of the total MME per prescription at the time of electronic prescription
- Add hard-stops to prescribing over the maximum MME, requiring an over-ride step
- Utilize team-based care to allow all staff to work at their highest level to support these steps (e.g., pharmacy, nursing, advanced practice professionals, support staff, etc.)
- Employ quality improvement processes and measures to monitor progress and potential unintended consequences.
- Assure that your opioid medication lists are reviewed for accuracy, and that your systems recognize tramadol and tapentadol products as opioids.

Quality Improvement Data and Measures

Quality improvement data and measures help with understanding small or limited tests of change within organizations. These tests of change often occur in early implementation of recommendations or new processes to discover whether the changes are leading to the expected improvement, which are the key elements of the change (those elements that should be replicated across settings) and which are elements that need adaptation (based on local resources, staff, patient population needs). This also allows comparability to increase the rapidity of learning across all involved systems.

Improvement aims and measures

Aim 1: Decrease the rate of opioid prescriptions to opioid naïve patient population.

Measure 1: Rate of opioid naïve patient population who receive an opioid prescription.

Data source and frequency of reporting: EMR data, collect and report data monthly for previous month's data.

Aim 2: Decrease the rate of inappropriate opioid prescribing to opioid naïve patient population.

Measure 2: Rate of opioid naïve patient population who receive an index short-acting prescription total >100 MME or a long-acting prescription during the measurement period.

Data source and frequency of reporting: EMR data, collect and report data monthly for previous month's data.

Internal quality improvement measure:

Aim 1: Decrease the mean MME of opioids prescribed and interquartile range.

Quality Improvement Measure 1: Short-Acting Initial Opioid Prescribed MME mean and range during the measurement period.

Data source and frequency of reporting: EMR data, monthly data collection and reporting for internal purposes only.

Nonsurgical Acute Pain Opioid Prescribing Measures and Specifications:

Measure 1 Description	Rate of opioid naïve patient population who receive an opioid prescription.
Measurement Period	Monthly
Eligible Population	Adults 18 years of age and over
Eligible Setting	The following within your system: ambulatory (non-surgical primary care and specialty care) clinic, urgent care, emergency department and dental (oral surgery) (if existing within your system).
Eligible Providers	Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Nurse Practitioner (NP), Advanced Practice Registered Nurse (APRN), Doctor of Dental Surgery (DDS), MBBS.
Exclusions	Patients who had an outpatient/inpatient surgical procedure at any time during the measurement period. Patients who were pregnant at any time during the measurement period. Patients who had active cancer diagnosis in the previous 12 months including the measurement period. Patients who were in palliative care or hospice care at any time during the measurement period.

<p>Denominator</p>	<p>Total patient population with a visit with an eligible provider in an eligible setting during the measurement period.</p> <ul style="list-style-type: none"> Visit: A completed or closed encounter (where applicable) at any of the eligible settings with an eligible provider that may or may not have been billed for. <p>Encounter types to include: Office visit (caveat: office visits may have a different meaning to each organization) Telephone MyChart Refill Nurse Triage Orders Only Patient Email</p> <p>Hospital encounters/hospital discharge encounters and procedure only encounters are excluded.</p> <ul style="list-style-type: none"> Count distinct patients only within each setting. Definition of distinct patient within each setting: a patient with multiple billable visits during the measurement period is counted <u>only</u> once. <p>Report this number separately by individual setting: ambulatory, urgent, ED and dental (oral surgery). See data submission excel template for data reporting.</p>
<p>Numerator</p>	<p>Total number of opioid naïve patients with an index (see below for definition) short-acting or index long-acting opioid prescription during the measurement period.</p> <p>Index prescription is initial (first) opioid prescription during the measurement period. If a patient received multiple prescriptions during the measurement period, count the first prescription only that they received. If multiple opioid prescriptions in one day, combine all of the prescriptions that were written on index date into one prescription. Be certain to include tramadol and tapentadol as opioids.</p> <p><u>Definition of opioid naïve:</u> No opioid (short-acting or long-acting) prescription (start date or order date) in the previous 90 days from the index opioid prescription start date or order date during the measurement period.</p> <p>Pull opioid prescription start date if available. If not, pull date of order.</p> <p>Report this number separately by individual setting: ambulatory, urgent, ED and dental (oral surgery). See data submission excel template for data reporting.</p> <p><u>Do not</u> count:</p> <ul style="list-style-type: none"> Historical opioid orders/prescriptions or patient reported opioid prescriptions received outside your system. <p>Opioid orders/prescriptions that were canceled (erroneous entries) or discontinued.</p>
<p>Unit of measurement</p>	<p>Percentage or number per 100 or 1000 patients.</p>

Measure 2 Description	Rate of opioid naïve patient population who receive an index short-acting prescription total >100 MME or a long-acting prescription during the measurement period.
Measurement Period	Monthly: January 2016-December 2019
Eligible Population	Adults 18 years of age and over at the start of measurement period.
Eligible Setting	The following within your system: ambulatory (non-surgical) clinic, urgent care, emergency department and dental (oral surgery) (if existing within your system).
Eligible Providers	Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Nurse Practitioner (NP), Advanced Practice Registered Nurse (APRN), Doctor of Dental Surgery (DDS)
Exclusions	<p>Patients who had an outpatient/inpatient surgical procedure at any time during the measurement period.</p> <p>Patients who were pregnant at any time during the measurement period.</p> <p>Patients who had active cancer diagnosis in the previous 12 months including the measurement period.</p> <p>Patients who were in palliative care or hospice care at any time during the measurement period.</p>
Denominator	<p>Numerator from Measure 1:</p> <p>Total number of opioid naïve patients with an index (see below for definition) short-acting or index long-acting opioid prescription during the measurement period.</p> <p>Index prescription is initial (first) opioid prescription during the measurement period. If a patient received multiple prescriptions during the measurement period, count the first prescription only that they received. If multiple opioid prescriptions in one day, combine all of the prescriptions that were written on index date into one prescription.</p> <p><u>Definition of opioid naïve:</u> No opioid (short-acting or long-acting) prescription (start date or order date) in the previous 90 days from the index opioid prescription start date or order date during the measurement period.</p> <p>Pull opioid prescription start date if available. If not, pull date of order.</p> <p>Report this number separately by individual setting: ambulatory, urgent, ED and dental (oral surgery). See data submission excel template for data reporting.</p> <p><u>Do not count:</u></p> <ul style="list-style-type: none"> • Historical opioid orders/prescriptions or patient reported opioid prescriptions received outside your system. • Opioid orders/prescriptions that were canceled (erroneous entries) or discontinued. • Short-acting opioid orders/prescriptions without MME conversion factor. <ul style="list-style-type: none"> ○ This does not apply to long-acting opioids since these do not require MME calculation and are only looked at as patient either received it or not.

<p>Numerator</p>	<p>Number of opioid naïve patients who receive an index short-acting prescription total >100 MME or an index long-acting prescription during the measurement period.</p> <p>The prescription total MME is per prescription, not per day. Index prescription is initial (first) opioid prescription during the measurement period. If a patient received multiple prescriptions during the measurement period, count the first prescription only that they received.</p> <p>If multiple opioid prescriptions in one day, calculate the combined total MME of all prescriptions on that day.</p> <p>Report this number separately by individual setting: ambulatory, urgent, ED and dental (oral surgery). See data submission excel template for data reporting. Short-Acting and Long-Acting Opioids List: Standard HEDIS* list or CDC** list as a reference. Both lists include MME Conversion Factor. Be certain to include tramadol and tapentadol as opioids.</p> <p>MME Calculator for reference (please follow up with pharmacist): # of pills x mg dose per pill=total mg total mg x MME Conversion Factor =Total MME</p>
<p>Unit of measurement</p>	<p>Percentage or number per 100 or 1000 patients.</p>

* Link to HEDIS medication list on NCQA website: <http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2018/hedis-2018-ndc-license/hedis-2018-final-ndc-lists> *The list may be updated frequently.*

Link to CDC medication list: <https://www.cdc.gov/drugoverdose/resources/data.html> *The list may be updated frequently.*

Link to Acute Non-Surgical Opioid data template: [Acute non-surgical opioid data template](#)

Contributing Member Organizations

This call to action would not be possible without the insights and practices shared by our community. We are grateful for their eagerness to collaborate on this important topic.

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Resources

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