

MN Health Collaborative Call to Action

Opioid Acute Non-Surgical Prescribing

Opioid Acute Pain Prescribing Working Group | V3 June 2019

The MN Health Collaborative includes physicians and other representatives from major healthcare organizations working together to address major health topics affecting Minnesota communities today, including opioid misuse and addiction and system improvements for broader mental health care needs. With a unique ability to conduct tests in the field, transparently share and learn from one another quickly, and implement shared standards for care, the MN Health Collaborative will disseminate best practices and learnings broadly as efforts progress.

The charter of MN Health Collaborative includes a specific goal to help reduce and eventually eliminate opioid overdose deaths, as well as provide better prevention and treatment practices for opioid addiction. These practices require a multi-pronged approach including stricter prescription guidelines, improved drug disposal, true care coordination, and stronger education and support for both patients and providers.

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Introduction

The Opioid Acute Pain Prescribing Working Group charge is 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 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

Geriatic Patients:

Geriatic 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.

Performance Data and Measures Reporting

All organizations are expected to report performance data and measures on acute (non-surgical) opioid prescribing. The results of the performance measures by individual organizations and collaborative overall will be shared among the collaborative. The performance measures are listed below and detailed specifications are in Appendix A.

Performance measures gauge system improvement efforts to impact implementation of changes on the overall system. While these measures are closely tied to the goals and aims of system change, determining optimal impact measures are often informed by quality improvement data collections. Additionally, since performance measures data must be “rolled up” to the system level, they benefit from detailed specifications and more rigorous testing than quality improvement 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.

Collaborative-wide performance 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.

Contributing Members and Organizations

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Resources

Edlund MJ, Martin BC, Russo JE, et al. The role of opioid prescription in incident opioid abuse and dependence among individuals with chronic noncancer pain: the role of opioid prescription. *Clin J Pain* 2014;30:557-64.

Hooten M, Thorson D, Bianco J, et al. Institute for Clinical Systems Improvement. Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management. Updated August 2017.

MN Health Collaborative Call to Action: Opioid Disposal Call to Action October 2017

National Academies of Sciences, Engineering, and Medicine. 2017. *Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/24781>.

Santistevan, JR, Sharp BR, Hamedani AG, et al. By Default: The effect of prepopulated prescription quantities on opioid prescribing in the emergency department. *WestJEM* 2018;19(2):392-97.

Shah A, Hayes CJ, Martin BC. Characteristics of initial prescription episodes and likelihood of long-term opioid Use — United States, 2006–2015. *MMWR* 2017;66:265–69.

[Appendix A1: Acute non-surgical opioid measures](#)

[Appendix A2: Acute non-surgical data submission template](#)