Measure 3 Overview: Percent of opioid prescriptions that met or exceeded 700 cumulative 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. 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

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