Opioid Prescribing Improvement Program: Quality improvement program feedback

This document provides recommendations based on the quality improvement (QI) projects submitted in 2021. While much of the work completed in 2021 resulted in improvement, there were some recurring misconceptions that limited success. The following summary is intended to help clinicians avoid common misconceptions and errors as they continue their internal quality improvement efforts.

Address the measure(s) indicated in the DHS Opioid Prescribing Report

Some prescribers did not completely understand the DHS opioid prescribing measure(s) requiring QI and the population included in the measure(s). While DHS acknowledges the overall improvements that support safe opioid prescribing, it is important that clinicians understand how to improve on all of the specific measures that are above threshold, or how to demonstrate alignment with best practices. Specific examples include:

- Measures 1 through 3 address prescribing to opioid naïve patients. An opioid naïve patient is someone with no active opioid prescription for 90 days prior to the first prescription. Quality improvement efforts should address those patients, rather than patients on chronic opioid therapy.
- Measures 5 and 6 represent patients on chronic opioid analgesic therapy and exclude patients in hospice care or with active cancer.

Differentiate between total and daily morphine milligram equivalence (MME)

Many QI reports indicated that prescribers may not differentiate between total and daily MME. MME is the prevailing metric for opioid dosing used by both DHS and the Centers for Disease Control and Prevention (CDC). MME is more clinically accurate than metrics of days or numbers of pills, and allows prescribers to gauge how different opioid formulations may expose the patient to a greater dose. Prescribers should address the MME thresholds as specified in the measure. This includes:

- Prescribing in the acute and post-acute pain phases (Measures 2 and 3) is calculated in the total MME of the prescription, meaning the total MME in the bottle. Use of daily MME or number of days is not an appropriate metric when prescribing for acute or post-acute pain.
- Measures 5 and 6 include patients on chronic opioid analgesic therapy (CAOT) and are calculated using daily MME doses (vs total MME).

Demonstrate opioid prescribing practices that align with standards of care

- In 2018, the Minnesota Departments of Health and Human Services published the Minnesota Opioid Prescribing Guidelines. This guideline reflects national standards, as well as regional improvement efforts to support prescribers and patients. DHS is aware that CDC revisions are underway, however no changes will be made to the Minnesota guidance in this calendar year.
An additional Minnesota resource is the Opioid Postoperative Prescribing Toolkit that includes an appendix of procedure-specific MME goals or benchmarks. This toolkit was developed by ICSI and surgeons across Minnesota.

Those who prescribe opioids in Minnesota, particularly those engaged in quality improvement, should demonstrate knowledge of and align with standards of care.

Identify barriers to improvement and use available supports

- While there are recognized barriers to best practice, DHS expects prescribers to make meaningful efforts to address challenges and barriers in their QI project.
- In most organizations, a QI liaison is available to support prescribers and their team members to successfully implement tests of change. DHS, and its clinical contractor, is also available for consultation.