Disclosures

• I have no actual or potential conflict of interest in relation to this topic or presentation

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  – Ontario Ministry of Health and Long Term Care (MOHLTC) Health System Research Fund (HSRF)
  – Ontario SPOR SUPPORT Unit
  – This study was also supported by ICES
Ontario’s Delisting Policy

July 20, 2016

Fentanyl: 75 and 100 mcg/hr patches
Morphine SR: 200 mg tablets
Hydromorphone CR: 24 and 30 mg capsules

January 31, 2017

Objective:
1. Regulate the availability of high-strength opioids in communities
2. Reduce the risk of prescription opioid-related harms
3. Prevent and reduce high daily opioid doses
Important Notes:

• **Exceptions** for patients receiving **palliative care**
  • Physicians registered with the palliative care facilitated access program, or through a prior authorization process

• **Similar daily doses** could be achieved with **lower strength** opioid formulations
  • Not intended to discontinue opioid use entirely or rapidly decrease doses

• **High-strength opioid** formulations available via other payment methods (i.e. **out-of-pocket, private insurers**)**
Publicly Funded Opioids:
- Shifts from high-strength opioids to lower strength opioids
- Significant reduction in volume of opioids dispensed

Qi, Guan, et al. Health promotion and chronic disease prevention in Canada: research, policy and practice 38.6 (2018): 256
Question: How did delisting high-strength opioids impact patient access to opioids and dose?
Question: How did delisting high-strength opioids impact patient access to opioids and dose?

Study Design: Population-based, longitudinal study

Population: Chronic publicly-funded, high-strength opioid recipients at the time of the policy (January 31, 2017)

Intervention Study Period: August 2016 to July 2017
  • 6 months pre/post policy

Historical Study Period: August 2015 to July 2016
  • For comparisons to intervention year
Measures of Interest:

1. **Dose:** Weekly median daily opioid dose (in milligrams of morphine equivalent; MME), of publicly funded opioid prescriptions and all opioid prescriptions

2. **Utilization:**
   a) Continued use of publicly-funded **high-strength** opioids
   b) Switch to **high-strength** opioids paid through other means
   c) Discontinuation of **all** publicly-funded opioids
   d) Discontinuation of **all** opioids paid through any means

**Stratifications:** Palliative care vs. non palliative care patients

**Data Sources:** Administrative healthcare data from ICES (e.g., ODB, NMS, CIHI-DAD, OHIP)
PATIENTS NOT RECEIVING PALLIATIVE CARE
Non Palliative Population Impact on opioid dose

Publicly-funded Prescriptions

Immediate ↓ 10 MME
↓ 0.9 MME per week
Non Palliative Population
Impact on opioid dose

Publicly-funded Prescriptions

All Prescriptions

Immediate ↓ 10 MME
↓ 0.9 MME per week

↓ 0.7 MME per week
Non Palliative Population
Impact on access to opioids

Measured in the 6 months following policy:

- Continued publicly funded high strength opioids: 2.3%
- Switch to non-publicly funded high strength opioids: ≤3.5%
- Discontinued ALL publicly funded opioids: 0.5%
- Discontinued ALL opioids: 0.4%

Percent (%)

0 10 20 30 40 50 60 70 80 90 100

Historical Year
Intervention Year
PATIENTS RECEIVING PALLIATIVE CARE
Publicly-funded Prescriptions

![Graph showing median daily dose (MME) over time period (weeks)]

- **Policy**: Level change: p=.21
- **Slope change**: p<.01

**↓ 3.9 MME per week**
Palliative Population
Impact on opioid dose

Publicly-funded Prescriptions

All Prescriptions

↓ 3.9 MME per week

No significant changes
Palliative Population
Impact on access to opioids

Measured in the 6 months following policy:

- Continued publicly funded high strength opioids: 98.6%
- Switch to non-publicly funded high strength opioids: 21.1%
- Discontinued ALL publicly funded opioids: ≤3.5%
- Discontinued ALL opioids: 0%

Percent (%)

- Historical Year
- Intervention Year
Discussion

• Some **shifts to cash/private payment** for high-strength opioids: more pronounced in **non-palliative patients**
  – February 2018: Nurse practitioners given authority to prescribe high-strength opioids to palliative patients

• No indication of abrupt discontinuation of opioids

• Small **reductions in the weekly median daily doses** dispensed. Safety implications of these changes require monitoring.
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Related Publications:


THANK YOU

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**Measures of Interest:** Weekly median daily opioid dose (in milligrams of morphine equivalent; MME), of publicly funded opioid prescriptions and all opioid prescriptions.

1. Calculate the daily dose for every day a person received an opioid prescription (in milligrams of morphine equivalent; MME)
2. Calculated the average of the daily opioid dose for each person every week
3. Reported the median of this measure across patients dispensed opioids each week.

**Statistical Analysis:** Interrupted time series analyses using linear segmented regression models testing for both trend (slope) and level changes (step).
Methods

Measures of Interest: Opioid Utilization:

a) Continued use of publicly-funded high-strength opioids
b) Switch to high-strength opioids paid through other means
c) Discontinuation of all publicly-funded opioids
d) Discontinuation of all opioids paid through any means

Statistical Analysis: Generalized estimating equations to account for the non-independence of observations since some individuals were represented in both cohorts.