Call to Action

The Safe Med LA Prescription Drug Abuse Coalition of Los Angeles County is a collaboration of many leading organizations focused on being part of the solution to the prescription opioid epidemic of overdoses and deaths in our community. Together we can reduce over-prescribing, improve pain management, and reduce the overuse, misuse, abuse, diversion of opioids, thereby improving and saving lives. We call upon each physician organization, health care system, and health plan to:

- **Respond to the Calls to Action from Safe Med LA, the Surgeon General, and the Centers for Disease Control, and**
- **Implement specific actions and interventions in your organization and practice that support evidence-based safe opioid prescribing.**

The Safe Med LA Medical Practice Tool Kit is designed to support your work with practical information, resources, tools, and best practices.

Call to Action:

- Surgeon General: Turn the Tide http://turnthetiderx.org/
- Centers for Disease Control and Prevention (CDC) https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
- MTV Documentary "Prescription for Change: Ending America's Opioid Crisis"
- Business Cases

Surgeon General: Turn the Tide

(http://turnthetiderx.org/)

LETTER FROM THE SURGEON GENERAL

Dear Colleague,

I am asking for your help to solve an urgent health crisis facing America: the opioid epidemic. Everywhere I travel, I see communities devastated by opioid overdoses. I meet families too ashamed to seek treatment for addiction. And I will never forget my own patient whose opioid use disorder began with a course of morphine after a routine procedure.

It is important to recognize that we arrived at this place on a path paved with good intentions. Nearly two decades ago, we were encouraged to be more aggressive about treating pain, often without enough training and support to do so safely. This coincided with heavy marketing of opioids to doctors. Many of us were even taught – incorrectly – that opioids are not addictive when prescribed for legitimate pain.

The results have been devastating. Since 1999, opioid overdose deaths have quadrupled and opioid prescriptions have increased markedly – almost enough for every adult in America to

have a bottle of pills. Yet the amount of pain reported by Americans has not changed. Now, nearly 2 million people in America have a prescription opioid use disorder, contributing to increased heroin use and the spread of HIV and hepatitis C.
I know solving this problem will not be easy. We often struggle to balance reducing our patients' pain with increasing their risk of opioid addiction. But, as clinicians, we have the unique power to help end this epidemic. As cynical as times may seem, the public still looks to our profession for hope during difficult moments. This is one of those times.

That is why I am asking you to pledge your commitment to turn the tide on the opioid crisis. Please take the pledge. Together, we will build a national movement of clinicians to do three things:

First, we will educate ourselves to treat pain safely and effectively. A good place to start is the TurnTheTideRx pocket guide with the CDC Opioid Prescribing Guideline. Second, we will screen our patients for opioid use disorder and provide or connect them with evidence-based treatment. Third, we can shape how the rest of the country sees addiction by talking about and treating it as a chronic illness, not a moral failing.

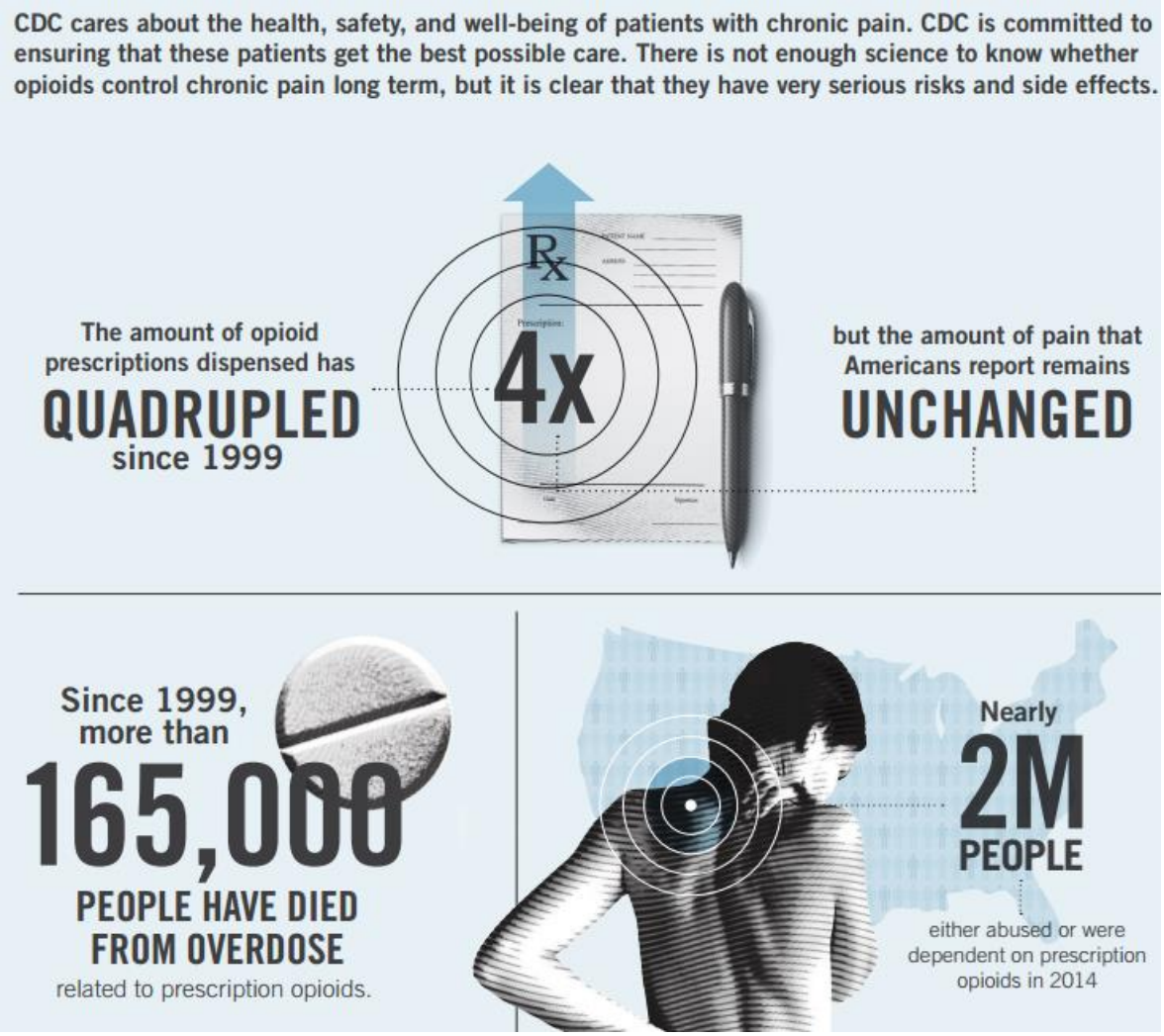
Years from now, I want us to look back and know that, in the face of a crisis that threatened our nation, it was our profession that stepped up and led the way. I know we can succeed because health care is more than an occupation to us. It is a calling rooted in empathy, science, and service to humanity. These values unite us. They remain our greatest strength.

Thank you for your leadership.

Vivek H. Murthy, M.D., M.B.A.
19th U.S. Surgeon General

Centers for Disease Control (CDC)
(https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm)

http://www.cdc.gov/drugoverdose/pdf/infographic-cdc_guideline_for_prescribing_opioids_for_chronic_pain-a.pdf



WHY GUIDELINES FOR PRIMARY CARE PROVIDERS?

http://www.cdc.gov/drugoverdose/pdf/guideline_infographic-a.pdf

WHY GUIDELINES FOR PRIMARY CARE PROVIDERS?

Primary care providers account for approximately

50%

of prescription opioids dispensed

Nearly

2 million

Americans, aged 12 or older, either abused or were dependent on prescription opioids in 2014

- An estimated 11% of adults experience daily pain
- Millions of Americans are treated with prescription opioids for chronic pain
- Primary care providers are concerned about patient addiction and report insufficient training in prescribing opioids

MYTH VS TRUTH

	MYTH	TRUTH
1	Opioids are effective long-term treatments for chronic pain	While evidence supports short-term effectiveness of opioids, there is insufficient evidence that opioids control chronic pain effectively over the long term, and there is evidence that other treatments can be effective with less harm.
2	There is no unsafe dose of opioids as long as opioids are titrated slowly	Daily opioid dosages close to or greater than 90 MME/day are associated with significant risks, and lower dosages are safer.
3	The risk of addiction is minimal	Up to one quarter of patients receiving prescription opioids long term in a primary care setting struggles with addiction. Certain risk factors increase susceptibility to opioid-associated harms: history of overdose, history of substance use disorder, higher opioid dosages, or concurrent benzodiazepine use.

WHAT CAN PROVIDERS DO?

First, **do no harm.** Long-term opioid use has uncertain benefits but known, serious risks. CDC's ***Guideline for Prescribing Opioids for Chronic Pain*** will support informed clinical decision making, improved communication between patients and providers, and appropriate prescribing.

PRACTICES AND ACTIONS

USE NONOPIOID TREATMENT

Opioids are not first-line or routine therapy for chronic pain *(Recommendation #1)*

In a systematic review, opioids did not differ from nonopioid medications in pain reduction, and nonopioid medications were better tolerated, with greater improvements in physical function.

START LOW AND GO SLOW

When opioids are started, prescribe them at the lowest effective dose *(Recommendation #5)*

Studies show that high dosages (≥100 MME/day) are associated with 2 to 9 times the risk of overdose compared to <20 MME/day.

REVIEW PDMP

Check prescription drug monitoring program data for high dosages and prescriptions from other providers *(Recommendation #8)*

A study showed patients with one or more risk factors (4 or more prescribers, 4 or more pharmacies, or dosage ≥100 MME/day) accounted for 55% of all overdose deaths.

AVOID CONCURRENT PRESCRIBING

Avoid prescribing opioids and benzodiazepines concurrently whenever possible *(Recommendation #12)*

One study found concurrent prescribing to be associated with a near quadrupling of risk for overdose death compared with opioid prescription alone.

OFFER TREATMENT FOR OPIOID USE DISORDER

Offer or arrange evidence-based treatment (e.g. medication-assisted treatment and behavioral therapies) for patients with opioid use disorder *(Recommendation #17)*

A study showed patients prescribed high dosages of opioids long-term (>90 days) had 122 times the risk of opioid use disorder compared to patients not prescribed opioids.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Opioids are commonly prescribed for pain. An estimated 20% of patients presenting to physician offices with noncancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receive an opioid prescription (*1*). In 2012, health care providers wrote 259 million prescriptions for opioid pain medication, enough for every adult in the United States to have a bottle of pills (*2*). Opioid prescriptions per capita increased 7.3% from 2007 to 2012, with opioid prescribing rates increasing more for family practice, general practice, and internal medicine compared with other specialties (*3*). Rates of opioid prescribing vary greatly across states in ways that cannot be explained by the underlying health status of the population, highlighting the lack of consensus among clinicians on how to use opioid pain medication (*2*).

Prevention, assessment, and treatment of chronic pain are challenges for health providers and systems. Pain might go unrecognized, and patients, particularly members of racial and ethnic minority groups, women, the elderly, persons with cognitive impairment, and those with cancer and at the end of life, can be at risk for inadequate pain treatment (*4*). Patients can experience persistent pain that is not well controlled. There are clinical, psychological, and social consequences associated with chronic pain including limitations in complex activities, lost work productivity, reduced quality of life, and stigma, emphasizing the importance of appropriate and compassionate patient care (*4*). Patients should receive appropriate pain treatment based on a careful consideration of the benefits and risks of treatment options.

Chronic pain has been variably defined but is defined within this guideline as pain that typically lasts >3 months or past the time of normal tissue healing (*5*). Chronic pain can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or an unknown cause (*4*). Estimates of the prevalence of chronic pain vary, but it is clear that the number of persons experiencing chronic pain in the United States is substantial. The 1999–2002 National Health and Nutrition Examination Survey estimated that 14.6% of adults have current widespread or localized pain lasting at least 3 months (*6*). Based on a survey conducted during 2001–2003 (*7*), the overall prevalence of common, predominantly musculoskeletal pain conditions (e.g., arthritis, rheumatism, chronic back or neck problems, and frequent severe headaches) was estimated at 43% among adults in the United States, although minimum duration of symptoms was not specified. Most recently, analysis of data from the 2012 National Health Interview Study showed that 11.2% of adults report having daily pain (*8*). Clinicians should consider the full range of therapeutic options for the treatment of chronic pain. However, it is hard to estimate the number of persons who could potentially benefit from opioid pain medication long term. Evidence supports short-term efficacy of opioids for reducing pain and improving function in noncancer nociceptive and neuropathic pain in

randomized clinical trials lasting primarily ≤12 weeks (*9*,*10*), and patients receiving opioid therapy for chronic pain report some pain relief when surveyed (*11*–*13*). However, few studies have been conducted to rigorously assess the long-term benefits of opioids for chronic pain (pain lasting >3 months) with outcomes examined at least 1 year later (*14*). On the basis of data available from health systems, researchers estimate that 9.6–11.5 million adults, or approximately 3%–4% of the adult U.S. population, were prescribed long-term opioid therapy in 2005 (*15*).

Opioid pain medication use presents serious risks, including overdose and opioid use disorder. From 1999 to 2014, more than 165,000 persons died from overdose related to opioid pain medication in the United States (***16***). In the past decade, while the death rates for the top leading causes of death such as heart disease and cancer have decreased substantially, the death rate associated with opioid pain medication has increased markedly (***17***). Sales of opioid pain medication have increased in parallel with opioid-related overdose deaths (***18***). The Drug Abuse Warning Network estimated that >420,000 emergency department visits were related to the misuse or abuse of narcotic pain relievers in 2011, the most recent year for which data are available (***19***). Although clinical criteria have varied over time, opioid use disorder is a problematic pattern of opioid use leading to clinically significant impairment or distress. This disorder is manifested by specific criteria such as unsuccessful efforts to cut down or control use and use resulting in social problems and a failure to fulfill major role obligations at work, school, or home (***20***)**. This diagnosis has also been referred to as "abuse or dependence" and "addiction" in the literature, and is** different from tolerance (diminished response to a drug with repeated use) and physical dependence (adaptation to a drug that produces symptoms of withdrawal when the drug is stopped), both of which can exist without a diagnosed disorder. In 2013, on the basis of DSM-IV diagnosis criteria, an estimated 1.9 million persons abused or were dependent on prescription opioid pain medication (***21***). Having a history of a prescription for an opioid pain medication increases the risk for overdose and opioid use disorder (***22–24***), highlighting the value of guidance on safer prescribing practices for clinicians. For example, a recent study of patients aged 15**–**64 years receiving opioids for chronic noncancer pain and followed for up to 13 years revealed that one in 550 patients died from opioid-related overdose at a median of 2.6 years from their first opioid prescription, and one in 32 patients who escalated to opioid dosages >200 morphine milligram equivalents (MME) died from opioid-related overdose (***25***).

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MTV Documentary

MTV one hour special "Prescription for Change: Ending America's Opioid Crisis," featuring President Obama and Grammy-award winning artist and recovery advocate Macklemore. (10/11/2016, 43 minutes)
http://www.mtv.com/full-episodes/heir4r/prescription-for-change-prescription-for-change-ending-america-s-opioid-crisis-ep-1

Business Cases to Support Safe Opioid Prescribing Practices

Even though the clinical quality and safety benefits of safe opioid prescribing speak for themselves, the "business case" for this work is often requested.

1. Quality/Safety: Plans would be in compliance to the CDC Guideline for Prescribing Opioids for Chronic Pain.
2. Decreased overdoses and deaths associated with prescription opioids.
3. Reduced pharmacy costs *(see Partnership Health Plan example below.)*
4. Decreased ED visits for opioid overdoses, drug seeking patients, and management of chronic pain will decrease overall health costs and free time in overcrowded EDs and Urgent Care.
5. Decreased hospitalizations for prescription opioid overdose will decrease overall health costs.
6. Requirements for performance measurement and reporting from NCQA/HEDIS, CMS, DHS, and others, which impacts public report cards, STAR ratings, pay for performance, and compliance with regulatory agencies.
7. Decrease the number of members getting started and becoming dependent on opioids for chronic pain. Once members get started on opioids to treat chronic pain, it is difficult to taper them off.
8. Will minimize the overall use of the health plan for drug seeking behavior- doctor office, dental office, Urgent care, ER, hospital, and pharmacy
9. Patient satisfaction with more effective pain management and substance use management for patients.

Partnership Health Plan:

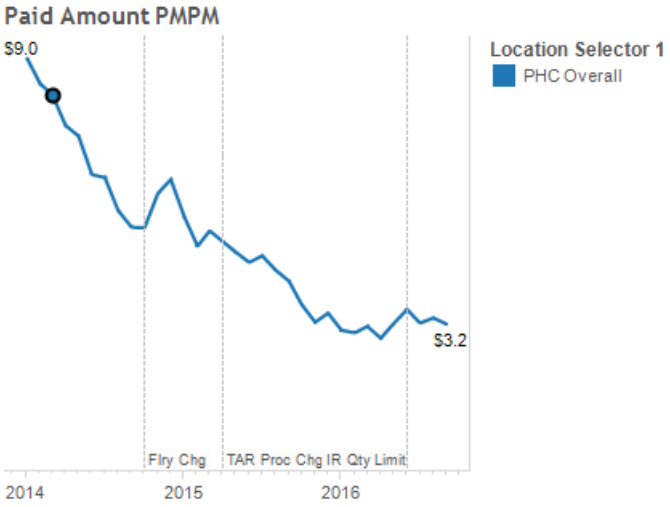
Partnership Health Plan data showed savings of almost $1 million per month in decreased cost of opioid meds (http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CaseStudiesHealthPlansOpioid.pdf).

Below is a graph showing the amount paid PMPM since MPS project start (January 2014). This shows a 64% decrease in the amount paid on opioid prescriptions PMPM Jan 14- June 16. All-opioid drug cost per 100 adult Medicaid members per month for opioid medications went from $9.60 to $2.90 over a 2 year period. Indirect health care savings (e.g., ED utilization, hospitalization) have not yet been calculated.

We didn't start MPS to save money. Although that may in fact be a balancing measure of our project, it wasn't the drive. We truly wanted to help our members be healthy and reduce the amount of overdose deaths in our

county. **We have seen a 73% decrease of members on unsafe dose (>120 mg MED) thus far. If the draw for health plans is to help their members, I think that statistic alone could help persuade plans to move forward.**

Danielle Carter, MPH, CPH
Project Manager | Quality Improvement Department, Partnership Health Plan of California



The trend of Paid Amt P100MPM for Fill Dt Month. Color shows details about Location Selector 1. The data is filtered on Fill Dt (Months), which ranges from Jan 2014 to Sep 2016. The view is filtered on Location Selector 1, which keeps multiple members.

Blue Shield of California:

Blue Shield just ran this data showing that, for the population on daily opioids, over time the decrease in total opioid prescribing was associated with a decrease in all cause ED and hospitalization. There may be some IBNR muddying the results, but the trend was encouraging. Marcus Thygeson, MD presented this at the CAHP meeting.

Organizing to Change

Every organization – physician group, care delivery system, health plan – is different. But to make changes that will result in safer opioid prescribing and quality pain management, there must be:

- Leadership Commitment
- Organized and accountable people and team(s) to:
    - Set Priorities
    - Develop Strategy and Plan
    - Implement specific actions, interventions
    - Monitor and oversee to achieve desired results

Simply sending a memo or distributing the CDC Guideline or "having a meeting" alone will not change practice or reduce opioid over-prescribing. As illustrated by the various sections of the Medical Practice Tool Kit, behaviors change when there are changes to work flow, care processes, new protocols, documentation, roles & responsibilities, and when there is measureable performance feedback to re-enforce desired outcomes.

Safe Med LA urges each dedicated physician group, care delivery system, and health plan, separately or together, to make the organizational commitment and follow through to establish an infrastructure to support and execute positive change toward safer opioid prescribing and pain management. If we all contribute to our part of the solution, together we can reduce the epidemic of opioid overdoses and deaths in our community.

The Safe Med LA Prescription Drug Abuse Coalition of Los Angeles County is here to help and support your efforts.

- **Check our website: www.safemedla.org**
- **Join our Medical Practice Action Team or Work Group**
- **Contact us:**

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Examples from Health Plans below:

- Anthem,
- Blue Shield
- Cigna
- Kaiser Permanente,
- LA Care
- Partnership Health Plan

Examples of organizational efforts:

California Health Care Foundation (CHCF) Reports:

- Case Studies: Three California Health Plans Take Action Against Opioid Overuse (June, 2016) http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CaseStudiesHealthPlansOpioid.pdf (Kaiser Permanente, Blue Shield, Partnership Health Plan)
- Changing Course: The Role of Health Plans in Curbing the Opioid Epidemic http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20ChangingHealthPlansOpioid.pdf
- Health Plan Rx for the Opioid Epidemic http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20H/PDF%20HealthPlansOpioidInfographic.pdf

Cigna:

May 19, 2016 Cigna plans to cut opioid use among U.S. customers by 25 percent

Health insurer Cigna Corp plans to cut its customers' prescriptions for opioid treatments by 25 percent over the next three years, putting its weight behind a U.S. government battle against addictive pain killers.

Cigna, whose plan to be acquired by Anthem, Inc. would make it part of the nation's largest health insurer, said on Thursday it is backing efforts by state governments to require doctors to check state databases for high-risk customers before prescribing opioid drugs for longer than 21 days.

As part of its plan, Cigna is to send doctors information from its own claims databases about its customers' prescription opioid use, enabling doctors to find out if prescriptions have been written elsewhere or if patients have been prescribed drugs to treat opioid addiction.

It will also work with physicians to educate them on prescribing guidelines and access to medication-assisted therapy to treat substance use disorders, Cigna's Chief Medical Officer for Behavioral Health Dr. Douglas Nemecek said in an interview.

Blue Shield of CA

June 29,2016

SAN FRANCISCO, CA (June 29, 2016) --- Blue Shield of California's Narcotic Safety Initiative, the health plan's three-year program to help its plan participants avoid opioid abuse and addiction, is seeing significant results in its first year.

In the program's first year, there has already been an 11 percent reduction in Blue Shield of California members using the very highest doses of opioids and a 5 percent reduction in those using moderately high doses of opioids. Additionally, Blue Shield has reduced the proportion of new opioid utilizers progressing to chronic use by 25 percent, and has seen an overall reduction in all opioid consumption.

These results are part of a new white paper released this week by the California Healthcare Foundation that looks at how health plans in California are helping to reduce opioid over-prescribing and ensure people have access to recovery services.
The study titled "Changing Course: The Role of Health Plans in Curbing the Opioid Epidemic" surveyed 30 California health plans on their efforts, and provides case studies of three health plans including Blue Shield of California.

"Health plans can help our communities – providers, patients and policymakers – return to a more rational level of opioid prescribing, while ensuring patients get the care they need," said Kelly Pfeifer, Director of High Value Care for the California Health Care Foundation in the news release that accompanied the paper.

Blue Shield's Narcotic Safety Initiative was launched in 2015 and its **goal is to reduce inappropriate prescribing and overuse of opioid narcotic medications for members by at least 50 percent by the end of 2018.**

"The focus of Blue Shield's program is twofold. We want to reduce unnecessary initial use of opioids for acute and chronic pain so that members are not unnecessarily exposed to the potential for chronic opioid dependence or addiction, and also promote safer opioid doses for those already on chronic opioid therapy," said **Marcus Thygeson, M.D., M.P.H., Blue Shield of California's Chief Health Officer**. "The opioid epidemic in the United States is a serious public health crisis, and we've made it a priority to work together with the rest of the healthcare delivery system to reduce opioid overuse."

Over the past 15 years, opioid prescriptions have quadrupled, leading to a cascade of interrelated health, social and economic problems. In addition, accidental deaths from drug overdoses exceed those caused by motor vehicle accidents and firearms, and more of these deaths are caused by prescription opioids (primarily hydrocodone and oxycodone) than heroin and cocaine combined. Hospital admissions for opioid addiction treatment have increased five-fold and five times as many babies now need treatment for opioid exposure than year 2000.

Another study recently released showed that about 1 in 550 people who started opioids died as a result of their ongoing opioid use after an average of two and a half years.

"There is still plenty of work to be done in overcoming the opioid epidemic and health plans are in a unique position to influence the behavior of both prescribers and patients," Thygeson said. "Together with the help of our community partners and providers, we can reduce the number of people getting started on chronic opioid treatment, continue to transition those already on chronic treatment to lower and safer doses of opioids, and put a stop to this dangerous public health crisis."

LA Care Health Plan

Strategies to Reduce Prescription Drug Abuse-- Lessons Learned from the ACAP SUD Collaborative-- APRIL 2015

L.A. Care Health Plan – Training on Motivational Interviewing Outreach to Providers: L.A. Care Health Plan's Collaborative project provides training on motivational interviewing to medical residents at two academic medical centers that deliver substance abuse treatment: Harbor

UCLA and Olive View Medical Centers. L.A. Care Health Plan's behavioral health staff conducted two one-hour training sessions for residents, and the health plan's Web site includes a SBIRT tool. Having a Physician Champion: The physician supervisor at the Harbor UCLA site—who is passionate about SBIRT's potential to effect positive change in beneficiaries' lives—has strongly supported the initiative. L.A. Care's Pharmacy Director noted that having a physician champion at the provider site was critical to the program's success. "It's helpful to find someone who cares as much as you do about making a change," she said. Patient Outreach for Motivational Interviewing: To find patients who could benefit from the program, L.A. Care analyzes pharmacy claims and identifies people who have three or more opioid prescriptions, use three or more pharmacies, and/ or have three or more prescribers. Health plan staff send these patients' files to the program director at Harbor UCLA and Olive View Medical Centers for review. Once the director verifies that an individual's care patterns suggest potential misuse or overuse of opioids,32 medical residents at Olive View conduct motivational interviewing at the patient's next scheduled visit. During the interviews, residents ask patients to identify important life goals and help them understand that seeking treatment and following care plans will enable them to reach those goals. At Harbor UCLA, medical residents meet with patients during routine clinic visits to gather information about their chronic pain and to initiate SBIRT and motivational interviewing. Residents refer patients who demonstrate readiness to engage in further treatment to the HOPE (Helping Overcome Pain Effectively) Clinic. The HOPE Clinic takes a holistic approach to treatment. An interdisciplinary team of providers—including a psychologist, medical resident, senior attending physician, and clinical pharmacist—meet with patients for as long as necessary, often for more than an hour. During these CHAPTER 2: HIGHLIGHTS OF COLLABORATIVE PROJECTS 7 appointments, clinicians educate patients about non-pharmaceutical adjunct therapies to manage pain. These include mindfulness exercises, acupressure, and brief psychological interventions. Clinicians use screening tools to further assess patients' potential for opioid misuse. Patients are asked to consider changes in their pain management regimens, and some are asked to decrease or discontinue opioid therapy. The clinic, which has been operating since October 2014, currently serves 20 patients. In the future, L.A. Care may add social workers and case managers to the program to connect patients with SUD services and help them follow treatment plans. Provider Payment for SBIRT: Although Medi-Cal reimbursement for SBIRT is limited to alcohol abuse treatment, medical residents participating in the program wanted to conduct motivational interviewing for patients with all types of SUD because they are interested in learning about best-practice models. Residents have been encouraged by patients' responses to the program, even in its initial stages. "It's exciting for them [the residents] that it [motivational interviewing] works," the project director said. Program Challenges Carve-Outs: Because substance abuse, serious mental illness, and SUD medications are carved out of Los Angeles County's Medicaid managed care program, L.A. Care's ability to track patients' use of SUD services is limited at best, and the health plan is unable to conduct an opioid replacement program. IT System Challenges: System transitions and difficulties with interoperability made analysis of patient data challenging. IT staff dedicated to the project developed effective solutions to move the project forward. Limited Access to Substance Abuse Treatment: In an effort to eliminate fraud and abuse that was prevalent among SUD treatment providers in the Medi-Cal program several years ago, the State of California now requires all providers to undergo recertification. The process has moved slowly

and has created a barrier to substance abuse treatment for Medi-Cal patients. Currently there is a wait list for care. Progress to Date: Based on the success of motivational interviewing with members participating in the project, medical residents have begun to conduct motivational interviewing

Anthem

Anthem Blue Cross Launches Program to Tackle Inappropriate Opioid and Rx drug use, Improve Drug Safety, Health Care Quality

Anthem Blue Cross has launched the Pharmacy Home Program to help high-risk members in individual and employer-sponsored plans reduce addiction to opioids and other prescription drugs and improve drug safety and healthcare quality by choosing one home pharmacy to fill their prescriptions.

More people died from drug overdoses in the United States in 2014 than during any previous year on record, according to the Centers for Disease Control, with nearly half a million people in the United States dying from drug overdoses between 2010-2014. Sixty percent of drug overdoses resulting in death involved narcotics. At least half of all opioid overdose deaths involve a prescription opioid.

"Clearly, the overuse and abuse of prescription drugs has evolved into a national epidemic and a public health emergency," said **Brian Ternan, president of Anthem Blue Cross**. "Health insurers are uniquely positioned to help improve prescription drug safety and healthcare quality as we have real-time access to information on medication use to determine if members are using multiple prescribers or several pharmacies to obtain their medications, which often correlates with addictive behavior."

The Pharmacy Home Program, which began on April 1 *(?? 2016)* with distribution of letters to eligible members, focuses on a small but extremely high-risk segment of members. Those who a have diagnosis or prescription history for HIV, sickle cell anemia, multiple sclerosis, cancer and hospice and palliative care are exempted from the program.

Even after overdosing on opioids – a class of painkillers — more than nine out of 10 people continued to get prescriptions for them, according to a 2015 study published in the Annals of Internal Medicine. And, some patients went on to suffer another overdose. Seventy percent of patients who overdosed later received prescriptions from the same health care professional who prescribed opioids before their first overdose.

"Collaborating with prescribers is key," said Ternan. "Because many medical information systems are not integrated, prescribers may not be aware that a member has overdosed or that a member is getting several prescriptions for the same drug or many, many other drugs from multiple doctors."

The Pharmacy Home program notifies prescribers in writing of the decision to include the member in the program. The prescriber will also receive a three-month member prescription history and an education piece on the advantages of one pharmacy to review with the member.

Members with increased safety risk and candidates for the Pharmacy Home program meet these criteria within a 90-day period:

- Filled five or more controlled-substance prescriptions, or filled 20 or more prescriptions, not limited to controlled substances
- Visited three or more health care providers for controlled substance prescriptions, or 10 or more providers not limited to controlled substances
- Filled controlled substances at three or more pharmacies, or filled prescriptions for 10 or more pharmacies not limited to controlled substances.

If the member does not change behavior as viewed in claim activity within 60 days of the first letter, the member will be mailed an enrollment letter requesting selection of a single pharmacy location to fill all medications, with a few exceptions, for a period of one year.

“We know from Anthem Medicaid plans that efforts like this can result in large drops in opioid prescriptions and lead to more appropriate treatment for substance abuse and pain management,” said Ternan. “This program is just one part of our overall strategy to help prevent addiction, re-direct members to appropriate care, and hopefully, prevent deaths and major medical problems from overdose and drug interactions.”

Safe Opioid Prescribing Guidelines

The CDC Guideline (March, 2016) is the most current evidence-based guideline and should be the cornerstone of safe opioid prescribing practices. – Safe Med LA

1. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 *Recommendations and Reports / March 18, 2016 / 65(1); 1-49*

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm\

This Guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The Guideline addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. CDC developed the Guideline using the grading of recommendations assessment development, and evaluation (GRADE) framework, and recommendations are made on the basis of a systematic review of the scientific evidence while considering benefits and harms, values and preferences, and resource allocation. CDC obtained input from experts, stakeholders, the public, peer reviewers, and a federally chartered advisory committee. It is important that patients receive appropriate pain treatment with careful consideration of the benefits and risks of treatment options. This Guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death. CDC has provided a checklist for prescribing opioids for chronic pain (http://stacks.cdc.gov/view/cdc/38025), as well as a website (http://www.cdc.gov/drugoverdose/prescribingresources.html) with additional tools to guide clinicians in implementing the recommendations.

- CDC Guideline Fact Sheet (2 pages): GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

https://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf

2. CDC NON-OPIOID TREATMENTS FOR CHRONIC PAIN (2 pages)

https://www.cdc.gov/drugoverdose/pdf/alternative_treatments-a.pdf

3. CDC POCKET GUIDE: TAPERING OPIOIDS FOR CHRONIC PAIN (4 pages)

https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

http://www.cdc.gov/drugoverdose/prescribing/resources.html

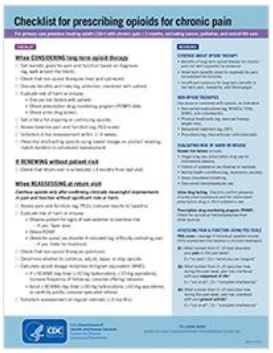
Pocket Guide: Tapering

Pocket Guide: Tapering Opioids for Chronic Pain [PDF - 2 MB]

Fact Sheet

Guideline for Prescribing Opioids for Chronic Pain: Recommendations [PDF - 690 KB]

Checklist*



Checklist for Prescribing Opioids for Chronic Pain [PDF - 537 KB]

Nonopioid Treatments

Nonopioid Treatments for Chronic Pain [PDF - 2 MB]

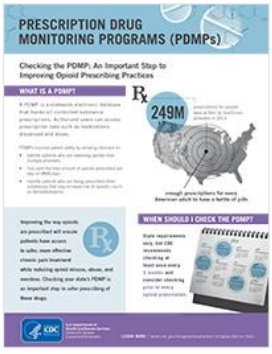
Assessing Benefits and Harms

Assessing Benefits and Harms of Opioid Therapy [PDF - 2 MB]

Calculating Dosage

Calculating Total Daily Dose of Opioids for Safer Dosage [PDF - 1 MB]

PDMPs



Prescription Drug Monitoring Programs (PDMPs) [PDF - 8 MB]

Infographic

Guideline Infographic: Why Guidelines for Primary Care Providers? [PDF - 2 MB]

Turn the Tide Pocket Guide

Turn the Tide Pocket Guide [PDF - 144 KB]

4. CDC Assessing Benefits & Harms of Opioid Therapy
https://www.cdc.gov/drugoverdose/pdf/assessing_benefits_harms_of_opioid_therapy-a.pdf

5. Surgeon General
PRESCRIBING OPIOIDS FOR CHRONIC PAIN
http://turnthetiderx.org/wp-content/uploads/2016/08/PocketGuide_FINAL6.pdf

SAFEMEDLA PRESCRIBING OPIOIDS FOR CHRONIC PAIN POCKET GUIDE
See attached pocket guide included in this section.

6. MEDICATION-ASSISTED TREATMENT OF OPIOID USE DISORDER Pocket Guide, Substance Abuse and Mental Health Services Administration (SAMHSA) (16 pages)
http://store.samhsa.gov/shin/content//SMA16-4892PG/SMA16-4892PG.pdf

OTHERS:

OREGON PAIN GUIDANCE PAIN TREATMENT GUIDELINES (May, 2016 Update)
http://professional.oregonpainguidance.org/wp-content/uploads/sites/2/2014/04/OPG_Guidelines_2016.pdf

The Oregon Pain Guidance group (OPG) created the OPG guidelines (May 2016 update) for everyone who manages patients with pain: prescribers, behavioral professionals, those who dispense pain medications, and those who pay for them. In preparing these guidelines, we reviewed and incorporated recommendations from the Washington state AMDG guidelines (June 2015) and the CDC guidelines (March 2016).

WASHINGTON STATE INTERAGENCY GUIDELINE ON PRESCRIBING OPIOIDS FOR PAIN (June, 2015)
http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

Developed by the Washington State Agency Medical Directors' Group (AMDG) in collaboration with an Expert Advisory Panel, Actively Practicing Providers, Public Stakeholders, and Senior State Officials.

DENTAL PRACTICE GUIDELINES:

PENNSYLVANIA GUIDELINES ON THE USE OF OPIOIDS IN DENTAL PRACTICE
http://www.ddap.pa.gov/Document%20Library/Presecriber%20Guidelines%20on%20the%20Use%20of%20Opioids%20in%20Dental%20Practice.pdf

OREGON PAIN GUIDANCE PAIN TREATMENT GUIDELINES (May, 2016 Update) -- RECOMMENDED OPIOID POLICY FOR DENTISTS Page 40
http://professional.oregonpainguidance.org/wp-content/uploads/sites/2/2014/04/OPG_Guidelines_2016.pdf

LOS ANGELES DENTAL SOCIETY
Advisory Statement on Opioids in Dental Practices:
http://www.ladental.com/latest-news

Physician Education Tools

Health plans, physician groups, and care systems are encouraged to sponsor and advocate educational programs to update clinicians about current, evidence-based safe opioid prescribing that are aligned with the CDC Guideline. A number of resources are available in this chapter to assist in organizing your own programs or referring clinicians to reputable programs.

1. **CDC Webinar Series CME**
   (https://emergency.cdc.gov/coca/calls/opioidresources.asp)

2. **Boston University SCOPE of Pain online CME**
   (https://www.scopeofpain.com/online-training)

3. **Providers' Clinical Support System for Opioid Therapies (PCSS-O) Webinar Series with CME**
   (http://pcss-o.org)

The following PodCasts are now available

on either iTunes or PCSS Podcast!

Episode 1: The CDC Opioid Guidelines

Episode 2: Myths and Misconceptions of Medication-Assisted Treatment

Episode 3: Buprenorphine Induction

Episode 4: Opioid Use Disorder

Episode 5: Applications of the CDC Guidelines

Episode 6: Use of Opioids

If you're using a PC and already have iTunes downloaded, click on the small gray box at the top of the iTunes page to access all podcasts if the PCSS podcast page doesn't automatically open.

Funding for this initiative was made possible (in part) by Providers' Clinical Support System for Opioid Therapies (grant no. 5H79T1025595) and Providers' Clinical Support System for Medication Assisted Treatment (grant no. 1U79T1026556) from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

4. **American College of Physicians (ACP) SAFE Opioid Prescribing: Strategies, Assessment, Fundamentals. Education, CME**
   (https://www.acponline.org/meetings-courses/focused-topics/safe-opioid-prescribing)

5. **AAFP (members only CME)**
   (http://www.aafp.org/cme/cmetopic/all/chronicopioidtherapy)

6. **UC Davis Pain Management ECHO Telementoring Program Project**
   (http://www.ucdmc.ucdavis.edu/advancingpainrelief/Projects/ECHO.html)

Medical Board of California Required CME on Pain Management and the Appropriate Treatment of the Terminally Ill

Most California-licensed physicians are required to take, as a one-time requirement, 12 hours of CME on pain management and the appropriate care and treatment of the terminally ill. Pathologists and radiologists are exempted from this requirement. The courses or programs must be presented by an organization accredited to provide CME by the ACCME, the AMA, the IMQ/CMA, or the AAFP. In addition to accrediting CME providers, AMA, IMQ/CMA, and AAFP may also present CME programs that will be accepted.

The 12 units may be divided in any way that is relevant to the physician's specialty and practice setting. Acceptable courses may address either topic individually or both topics together. For example, one physician might take three hours of "pain management education" and nine hours of "the appropriate care and treatment of the terminally ill;" a second physician might opt to take six hours of "pain management" and six hours of "the appropriate care and treatment of the terminally ill;" a third physician might opt to take one 12-hour course that includes both topics. The Medical Board will accept any combination of the two topics totaling 12 hours.

Physicians must complete the mandated hours by their second license renewal date or within four years, whichever comes first. The 12 required hours would count toward the 50 hours of approved CME each physician is required to complete during each biennial renewal cycle.

Patient Information

These may be useful in your practice to communicate current evidence-based clinical guidelines and to educate patients and consumers about safe and effective pain management.

1. CDC Patient Information Resources

a) **CDC Patient Poster**
https://www.cdc.gov/drugoverdose/pdf/guidelines_patients_poster-a.pdf

b) CDC Guideline Information for Patients: Safe, More Effective Pain Management
http://www.cdc.gov/drugoverdose/prescribing/resources.html **(see below**)**
http://www.cdc.gov/drugoverdose/prescribing/patients.html

i. About Opioids Screenshot
ii. Opioid Prescribing Guideline Screenshot
iii. If You Are Prescribed Opioids Screenshot
iv. Nonopioid Options
v. Help and Resources

2. Choosing Wisely Patient/Consumer Resources

a) Do you have ongoing pain that is not from cancer or a terminal illness? (2 pages) (http://consumerhealthchoices.org/wp-content/uploads/2016/04/ChoosingWiselyOpioids-ER.pdf)
b) Choosing Wisely Brochure: Avoid Opioids for Most Long Term Pain (English & Spanish, 4 pages) (http://consumerhealthchoices.org/wp-content/uploads/2016/05/ChoosingWiselyOpioidsBrochure-ER.pdf)
c) Medicines to Relieve Chronic Pain (English & Spanish, 2 pages) http://consumerhealthchoices.org/catalog/medicines-relieve-chronic-pain-asa/
d) Treating Frequent Headaches with Pain Relievers (English & Spanish, 2 pages) (http://www.choosingwisely.org/patient-resources/treating-frequent-headaches-with-pain-relievers/)
e) Treating Migraine Headaches (English & Spanish, 2 pages) (http://www.choosingwisely.org/patient-resources/treating-migraine-headaches/)
f) Back Pain Tests and Treatments (4 pages) (http://www.choosingwisely.org/patient-resources/back-pain-tests-and-treatments/)

3. Surgeon General's Turn the Tide Patient Information Resources

http://turnthetiderx.org/for-patients/#

a) About Opioids Screenshot
b) Manage Your Pain Screenshot
c) Taking Opioids
d) Safe Storage and Disposal Screenshot
e) Help Is A Call Away
http://www.samhsa.gov/find-help/national-helpline

Opioid use disorder can occur when a patient has a hard time controlling his or her opioid use, which results in significant health or social problems. There are effective treatments for opioid use disorder. If you or someone close to you has an addiction to pain medication, talk to your health care professional or

contact the Substance Abuse and Mental Health Services Administration's (SAMHSA) TREATMENT HELP LINE at (800) 6662-HELP (4357) or visit the online treatment locators.

[SAMHSA's National Helpline (also known as the Treatment Referral Routing Service) is a confidential, free, 24-hour-a-day, 365-day-a-year, information service, in English and Spanish, for individuals and family members facing mental health and/or substance use disorders. This service provides referrals to local treatment facilities, support groups, and community-based organizations. Callers can also order free publications and other information.]

4. LA County Department of Public Health: Substance Abuse Prevention and Control (SAPC) http://publichealth.lacounty.gov/sapc/

** From Above:

1. CDC Patient Information Resources

b). CDC Guideline Information for Patients: Safe, More Effective Pain Management

http://www.cdc.gov/drugoverdose/prescribing/resources.html

What You Need to Know

Prescription Opioids: What You Need to Know [PDF - 1 MB]

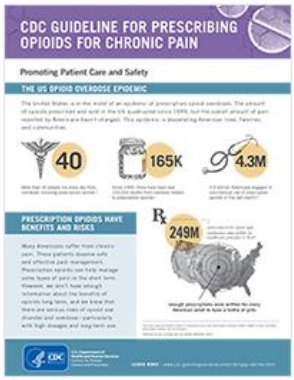
Opioids and Chronic Pain

Guideline Factsheet for Patients: Promoting Safer and More Effective Pain Management [PDF - 890 KB]

Pregnancy and Opioids

Pregnancy and Opioid Pain Medications [PDF - 1 MB]

At-A-Glance

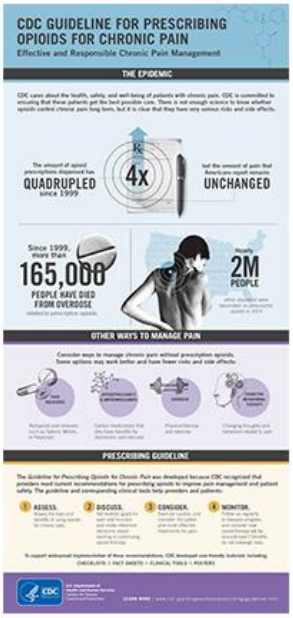


CDC Guideline for Prescribing Opioids for Chronic Pain: At a Glance [PDF - 2 MB]

Infographic

Guideline Infographic: Why Guidelines for Primary Care Providers? [PDF - 2 MB]

Infographic



Infographic: CDC Guideline for Prescribing Opioids for Chronic Pain [PDF - 939 KB]

Policies, Procedures, & Protocols

Putting safe opioid prescribing evidence-based guidelines into practice is supported with the adoption of specific policies, procedures, and protocols by physician groups, care systems, and/or health plans.

(The Tool Kit section on Clinical Decision Support "hardwires" these policies/procedures/protocols through tools embedded in the EMR or other work flow protocols.)

a. <u>CURES Use</u>

Establish a routine practice for when it is appropriate for clinicians (and pharmacists) to check the CURES database when considering prescribing an opioid medication. SB482 was signed into law by the Governor on September 27, 2016 and provides a guide for designing that policy/protocol.
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB482

> *A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.*
>
> *If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption …, to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient, he or she shall consult the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.*

b. <u>Formulary/Medication Use</u>:

1) **Restricted prescribing of opioids to specialists**, e.g. long acting, high risk opioids restricted to pain management, oncology, and hospice/palliative care clinicians only.
2) **Quantity Limits:** Establish maximum quantity limits for specific opioid medications, e.g., 3 days, 5 days, 7 days, or maximum 30 days without refills.
3) **Daily Dosing Limits**: Clinical guidelines describe various thresholds for MME/day (Mg Morphine Equivalents) to assure safe opioid prescribing – 50 MME/day, 90 MME/day, 100 MME/day, 120 MME/day. Such thresholds may trigger pharmacy review, peer review, pre-authorization, or escalation.
4) **Combination Medication Prescribing:** Avoid prescribing of opioid + benzodiazepine or opioid + carisoprodol prescribing.
5) **Naloxone Use and Co-Prescribing:** Co-prescribing of Naloxone (Narcan) in specific clinical situations can be supported, e.g., for high risk chronic opioid using patients on > 200 MME/day, past history of OD, etc.

6) **Tapering Protocols:** A consistent protocol can aid clinicians in physician groups/care systems with an acceptable and safe guide to tapering chronic opioid using patients on high MME/day doses to lower safer daily doses or discontinuation of the opioid medication.
7) **Follow-up rules for Chronic Opioid Patients:** The Medical Board of California (MBC) advises that patients on chronic opioids should be seen "monthly, quarterly, or semiannually, as required by the standard of care." (http://www.mbc.ca.gov/About_Us/Laws/laws_guide.pdf) With such a policy, a tickler/reminder file can assure such patients are brought back in for re-visits with the prescribing clinician, as guided by the policy or protocol set up by the physician practice, care system, or health plan..

c. <u>Pre-authorization</u>

To assure safe and appropriate opioid prescribing, specific indicators (red flags) may trigger more intense (just-in-time) review, including pre-authorization (or Pre-Peer review) before a prescription may proceed to fulfillment. Some of these indicators may follow from the Formulary/Medication Use policies above.

d. **<u>Inter-Specialty Cooperation and Relationships:</u>**

Managing difficult pain patients requires the help of colleagues and other team members. Establishing working rules/agreements for when informal and formal consultation, advice, or referral is appropriate can assure safe and appropriate pain management, prescribing, and substance use management.

1) **Inter-specialty Working Agreements:** SCPMG established such an agreement
2) **When should patients be referred to Pain Management or Substance Use Management?**
3) **Multi-specialty Pain Management Task Force/Huddle/Review Team/Committee:** Formation of a multi-specialty team can be useful in collaborative case review/consultation for difficult patients, as well as pro-active review of identified high risk patients (high MME/day, frequent fliers, etc.) and high prescribing clinicians.

e. **<u>Education:</u>**

With the emergence of new scientific evidence and new clinical guidelines, ongoing (re-) education of clinicians is critical to assuring up-to-date safe opioid prescribing and pain management. Some physician groups and professional organizations are advocating and sponsoring "required" CME on safe and appropriate opioid prescribing and pain management for their medical staff and members.

- **Example:** SCPMG currently requires all new physicians, residents, and fellows to complete a minimum 3-hour online CME on safe opioid prescribing, from Boston University's SCOPE of Pain program (https://www.scopeofpain.com/online-training/). BU tracks and reports to SCPMG on which clinicians have completed the program. For more information, contact Steve Steinberg, MD (steven.g.steinberg@kp.org)

f. <u>Medication Assisted Treatment (MAT)</u>

Some chronic opioid using patients have substance use disorder and will benefit from substance abuse treatment, including MAT with buprenorphine, which can be prescribed by clinicians (addiction medicine and primary care) who have a DEA waiver to prescribe for addiction management. Physician groups, care systems can establish and design programs to assure the availability of trained physicians with the waiver in each practice/facility, who can provide access to such life-saving treatments.

- **Medication-Assisted Treatment of Opioid Use Disorder- Pocket Guide**
  http://store.samhsa.gov/shin/content//SMA16-4892PG/SMA16-4892PG.pdf
- **Buprenorphine Training for Physicians**
  http://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training
- **Apply for a Waiver**
  http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/apply-for-physician-waiver

g. Pharmacy Collaboration

Professional collaboration between clinicians and pharmacists can help support safe opioid prescribing practice. Pharmacies can/should adopt protocols with red flags for when further consultation and review with the prescribing clinicians is indicated. Joint development and review of these protocols is recommended to assure a collaborative clinical relationship.

- **Example:** SCPMG jointly developed Policies and Procedures with the Kaiser Pharmacy Operations, where certain red flags (high doses, high quantity, drug combinations) trigger pharmacist review with calls to the prescribing clinician and occasional escalation to Chief of Service for questionable prescribing.

Clinical Decision Support

Clinical Decision Support refers to specific tools, aids, and protocols that are built into work flow to make it easier to do the right thing, i.e., evidence-based safe and appropriate opioid prescribing and pain management.

a. Electronic Medical Record – Alerts, Order Entry Questionnaires, Best Practice, Protocols, Menus

1) Medication Safety Alerts – Dose, Age, Quantity, Combinations, Frequent Refill
2) Best Practice Alerts – alternative treatment options, tapering protocol, consultation/referral
3) Order Entry Questionnaires – criteria to meet, approved specialty, etc.
4) CURES
    a. CURES Use Alerts
    b. Link to CURES
5) Treatment Agreements
6) Coding Tools
7) Urine Drug Testing
8) Default Sig on Prescriptions (small quantity, no refills)
9) DR.ADVICE tool for EMR supported email advice from specialists

b. Protocols: with or without the EMR, protocols support safe prescribing.

1) CURES Check
2) Duration of therapy maps/template (3d, 5d, 7d, 30 d)
3) Default Rx Sigs
4) Alternative Treatment Protocols
5) Urine Drug Testing (UDT)
6) Treatment Agreement
7) Tapering Protocol
8) Consultation/Referral Protocol
9) Naloxone co-prescribing for high risk / high dose chronic opioid patients

c. How to Deal with Difficult Patients (Advice, Consultation, Referral)

1) Advice Line Access (phone, email with or without EMR support)
2) Consultation/Referral Guidelines/Protocol
3) Organizational, Multi-specialty Controlled Substance/Opioid/Pain Management Review Team

d. After Visit Summary

1) Shared template AVS for Treatment Agreements, Patient Consent, Pain Management (Migraine, Low Back, Fibromyalgia, Chronic Pain, Opioids)
2) Use of standard Patient Information Tools, e.g., Choosing Wisely, CDC (see Patient Information/Education Section)

e. Nursing Staff Roles and Tools

1) Staff education around safe prescribing and use

f. Clinical Pharmacist/Pharmacy

1) Pharmacy Protocols (CURES check, quantity limits, early refill, frequent fliers, multiple prescribers, combination medications (e.g., opioid + BZP), high daily dose

g. Utilization Management/Utilization Review

1) Can be conducted in real time or retrospectively using data that can identify prescribing improvement opportunities.

Pain Management and Substance Use (Addiction Medicine) Management Advice & Support

Your medical group / physician group may have existing relationships with pain management/substance abuse departments that they should take advantage of. It may also be valuable to check with health plans to make use of pain management and substance abuse services that are available through each respective health plan. For example, one of the documents in this section illustrates the relationship between Blue Shield and Magellan.

1. **UCSF Clinical Consultation Center (CCC) Substance Use Warmline**
   http://nccc.ucsf.edu/clinical-resources/substance-use-resources/
   http://nccc.ucsf.edu/clinician-consultation/substance-use-management/

   Substance Use Management: Clinically supported advice on substance use management for health care providers. Peer-to-peer consultation from physicians, clinical pharmacists, and nurses with special expertise in substance use evaluation and management.
   Call for a Phone Consultation: 855-300-3595 (Monday-Friday, 10am – 6pm EST)

2. **UC Davis Pain Management ECHO Telementoring Program Project**
   (http://www.ucdmc.ucdavis.edu/advancingpainrelief/Projects/ECHO.html)

3. **Blue Shield / Magellan Contact Sheet**

4. **County of Los Angeles Substance Abuse Prevention and Control List**
   http://nebula.wsimg.com/ba638bf5557aafecfae859e8488b9803?AccessKeyId=5647EEC704480FB09069&disposition=0&alloworigin=1

5. **Smartphone App Helps Physicians Treat Opioid Abuse**
   http://www.physiciansnewsnetwork.com/connected_care/article_d5cd0d02-a10f-11e6-8760-63fada63a229.html?utm_medium=social&utm_source=email&utm_campaign=user-share

6. **Surgeon General's Website: Turn The Tide: Help Is A Call Away**
   http://turnthetiderx.org/for-patients/#
   HELP IS A CALL AWAY: Opioid use disorder can occur when a patient has a hard time controlling his or her opioid use, which results in significant health or social problems. There are effective treatments for opioid use disorder. If you or someone close to you has an addiction to pain medication, talk to your health care professional or contact the Substance Abuse and Mental Health Services Administration's (SAMHSA) TREATMENT HELP LINE at (800) 6662-HELP (4357) or visit the online treatment locators.

   [SAMHSA's National Helpline (also known as the Treatment Referral Routing Service) is a confidential, free, 24-hour-a-day, 365-day-a-year, information service, in English and Spanish, for individuals and family members facing mental health and/or substance use disorders. This service provides referrals to local treatment facilities, support groups, and community-based organizations. Callers can also order free publications and other information.]
   http://www.samhsa.gov/find-help/national-helpline

Coordination with Pharmacy (ies)

COMING SOON…

Data and Performance Measurement
Quality Improvement/Performance Improvement

Prescribing data is essential to understanding if a problem exists, targeting to manage opportunities for improvement, monitoring progress over time, and providing performance feedback to clinicians and clinical leaders. Acquiring useful data and specific metrics can be a challenge, and calls for cooperation among health plans, care delivery systems, physician groups, and potentially pharmacies/Pharmacy Benefit Managers (PBMs). We encourage all parties to collaborate to develop and support ongoing data measurement, reporting, and monitoring.

What gets measured can be improved. The next step is to prioritize performance improvement in opioid prescribing for your organizational QI program, using the typical QI/PI approaches, including PDSA, redesign, program planning, performance review and feedback, monitoring and oversight. In some organizations, the Board has established safe opioid prescribing as an important priority, with accountability to the Board, but accountability for improvement can be to senior leadership, departmental or organizational leadership.

Other References/Resources

California Health Care Foundation (CHCF):

Opioid Safety Coalitions Network
http://www.chcf.org/oscn

Opioid Safety
http://www.chcf.org/topics/opioid-safety?page=1

American Academy of Family Physicians (AAFP)

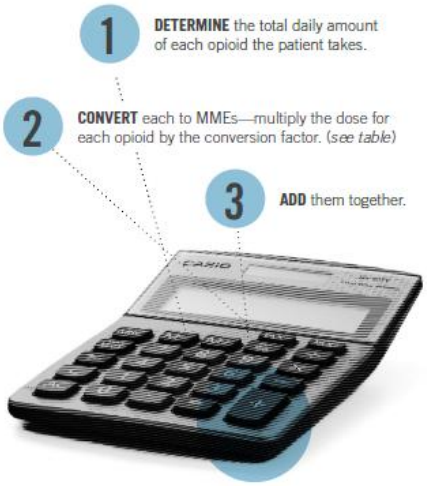
Pain Management and Opioid Abuse Resources (Office-base Tools, Community Engagement,
Science & Education)
http://www.aafp.org/patient-care/public-health/pain-opioids/resources.html

AAFP Chronic Pain Management Tool Kit
http://www.aafp.org/content/dam/AAFP/documents/patient_care/pain_management/restricted/cpm-toolkit.pdf

CDC Opioid Conversion Guide

https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?



Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

CAUTION:

- Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

USE EXTRA CAUTION:

- **Methadone:** the conversion factor increases at higher doses
- **Fentanyl:** dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors

Opioid Calculator App by FPM ANZCA

http://www.patientcareonline.com/pain/opioid-calculator-fpm-anzca-app-review this app helps prescribers calculate MME doses for safe prescribing purposes.

Safe Drug Disposal and Sites in LA County

https://dpw.lacounty.gov/epd/hhw/nodrugs.cfm
http://ladpw.org/epd/hhw/pdf/SheriffsSites.pdf that provides the 21 Sheriff Drug Dropbox locations throughout the County.

Buprenorphine Questions & Answers (from CHCF)

http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20B/PDF%20BuprenorphineFAQ.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA)

http://www.samhsa.gov/ Home Page

http://www.samhsa.gov/atod/opioids
Get the facts on the misuse and abuse of prescription opioids such as hydrocodone, oxycodone, morphine, and codeine, and the illegal opioid, heroin.

Safe Med LA Prescription Drug Abuse Coalition of Los Angeles County

Home Page
www.safemedla.org/

Safe Pain Prescribing Resources and Guidelines
http://www.safemedla.org/safe-prescribing-guidelines-and-resources.html

Los Angeles County Department of Public Health: Substance Abuse Prevention and Control (SAPC)

Home Page: http://publichealth.lacounty.gov/sapc/