TOOLKIT: Safe Pain Medicine Prescribing in Emergency Departments and Urgent Care Centers

Safe Med LA: Safe Prescribing Medical Practice Action Team

Los Angeles County Medical Association

KAISER PERMANENTE

Health Services LOS ANGELES COUNTY

County of Los Angeles Public Health

HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA

CALIFORNIA ACEP

Safe Pain Medicine Prescribing in Emergency Departments and Urgent Care Centers:

Safe Med LA: Safe Prescribing Medical Practice Action Team

Dear Emergency Department and Urgent Care Colleagues:

This is to provide you information on a set of tools and resources made available to support your efforts to use the patient handout titled "Safe Pain Medicine Prescribing in Emergency Departments and Urgent Care Centers."

This patient education effort is supported by the Los Angeles County Prescription Drug Abuse Medical Task Force (turn over for a list of members). The Task Force's goal is to encourage all Emergency Departments in the County to provide the patient handout to all patients upon discharge from the Emergency Department. Consistent use of this handout in your Emergency Department will allow the entire LA County community to establish safe, appropriate norms surrounding the use of pain medications in all Emergency Departments while at the same time improving patient outcomes.

"Rules" listed in the patient handout provide information to patients and have been approved by the California chapter of the American College of Emergency Physicians (CAL ACEP). These "rules" are not intended to proscribe or in any way limit good medical practice. Physicians remain in charge of patient care and have full discretion to make decisions about the medical care that is most appropriate for and best meets the needs of each patient.

This toolkit includes all of the following:

1. Clinical Practice Guidelines
2. Controlled Prescriptions: Questions and Answers
3. Patient Materials
4. Safe Prescribing Implementation
5. Guidance concerning the Emergency Medical Treatment and Active Labor Act (EMTALA)
6. Chronic Pain Screening and Monitoring Tools
7. Resources for Pain Management and Substance Use Disorder Management and Treatment
8. Other Resources
9. Appendix: Background Information, Data, and Goals
10. Emergency Department and Urgent Care Addresses
11. Community Clinic and Health Center Addresses
12. Medical Practice Action Team Roster

All resources in this toolkit as well as additional information and resources are available in electronic format at: http://www.SafeMedLA.org

If you have questions or comments regarding this TOOLKIT or the work of the Task Force, please contact us at:

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We ask for your help and support:

- **Emergency Departments and Major Provider Groups with Urgent Care Clinics/Centers**
- **Delivery Systems with Urgent Care Clinics/Centers & Emergency Departments**
- **IPA/PPOs with Urgent Care Clinics/Centers & Emergency Departments**
- **Independent Urgent Care Clinics/Centers & Emergency Departments**

Please

1. **Adapt, Adopt, and implement the AAEM Practice Guidelines**
2. **Communicate and share with patients, family members, and consumers**
3. **Redirect patients to primary care, pain management, and addiction medicine resources**

TOOL KIT

This Tool Kit includes information, resources, and supporting materials to help you accomplish this within your organizations.

Thank you for your commitment to address the epidemic of opioid over-prescribing in our community.

SafeMedLA: Prescription Drug Abuse Coalition of Los Angeles County

Table of Contents

Clinical Practice Guidelines

This section of the toolkit includes four guidelines:

- Emergency Department Opioid Prescribing Guidelines for the Treatment of Non-Cancer Related Pain (American Academy of Emergency Medicine, 2013)
- Guideline For Prescribing Opioids For Chronic Pain (Center For Disease Control, 2016)
- 2015 Washington State Interagency Guidelines on Prescribing Opioids for Pain
- Clinical Guidelines Flowchart for Evaluation and Treatment of Chronic Non-Cancer Pain (Alameda County Health Care Services Agency, 2016, adapted from the Oregon Pain Guidance Opioid Prescribing Guidelines 8/2014)

Clinical Practice Statement

Emergency Department Opioid Prescribing Guidelines for the Treatment of Non-Cancer Related Pain (11/12/2013)

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Reviewed and approved by the AAEM Board of Directors 11/12/2013.

Executive summary

Pain is one of the most common chief complaints among emergency department patients with a reported rate of over 50%.[1] There is great variability among emergency clinicians in the management of pain, especially with respect to the use of opioid medications.[2] Importantly, morbidity and mortality have increased as the frequency of opioid use for the treatment of pain has increased.[3] This includes a significant increase in non-medical opioid use, addiction, drug-related emergency department visits, and death.[4,5] The dangers of prescribing opioid medications extend beyond the individual patient and may adversely impact public health.[6] Approximately 13% of high school seniors have reported non-medical use of prescription opioids. Despite emergency departments prescribing only a fraction of those prescriptions written nationally, ED prescriptions for opioids are reported to account for approximately 45% of those opioids diverted for non-medical use.[7]

These guidelines were developed to provide the emergency clinician with recommendations regarding the safe, effective, and ethical practice of pain management in the emergency department setting. These recommendations may be adopted in whole or in part and should be adapted to address individual hospital policies along with state and local regulations. This document is not meant to replace the judgment of the treating clinician who is in the best position to determine the needs of the individual patient.

Recommendations

In the management of the emergency department patient presenting with acute or chronic pain, the emergency clinician should consider the following when prescribing an opioid medication:

1. **Administer a short-acting opioid analgesic for the treatment of acute pain as a second-line treatment to other analgesics unless there is a clear**

indication for the use of opioid medication (Example-patient with acute abdomen, long bone fracture, etc).

2. **Start with the lowest effective dose of an opioid analgesic.**

3. **Prescribe a short course (up to 3 days) of opioid medication for most acute pain conditions.**

4. **Address exacerbations of chronic pain conditions with non-opioid analgesics, non-pharmacological therapies, or referral to pain specialists for follow-up.**

5. **Consider assessing for opioid misuse or addiction using a validated screening tool.**

6. **Consider accessing a centralized prescription network or state-based prescription drug monitoring program, when available, for patient information on recent controlled substance prescriptions.**

7. **Refrain from initiating treatment with long-acting, or extended-release, opioid analgesics such as methadone.**

8. **Avoid prescribing opioid analgesics to patients currently taking sedative-hypnotic medications or concurrent opioid analgesics.**

9. **Refrain from replacing prescriptions for lost, stolen, or destroyed opioid prescriptions.**

10. **Refrain from refilling chronic opioid prescriptions. Refer the patient to the treating clinician who provided the original prescription.**

11. **Encourage prescribers to provide safety information about opioid analgesics to patients. This could include information on the risks of overdose, dependence, addiction, safe storage, and proper disposal of unused medications.**

12. **Following treatment with opioids (in particular the parenteral form) consider an appropriate period of observation and monitoring before a patient is discharged.**

13. **Understand EMTALA and its requirements for the treatment of pain. The emergency clinician is required under EMTALA to evaluate an emergency department patient reporting pain. The law allows the emergency clinician to use clinical judgment when treating pain and does not require the use of opioids.**

Opioid prescribing is associated with potential misuse and future dependence.[8, 9] [10] Though attempts can be made to mitigate this, there are no set of predictors that can determine all patients at risk for opioid abuse.[11] This should be reserved for only the most painful conditions using good clinical judgment.

Higher doses of opioids are associated with an increased risk of opioid overdose deaths.[12, 13] In addition, increased doses are also associated with an increased risk of abuse.[9]

Few acutely painful conditions treated in the emergency department require more than a short 3-day course of opioid therapy.[14] Longer courses of opioid treatment are associated with increased risk of abuse[8] and disability.[15] In addition, opioid use beyond 3 days results in diminished efficacy and potential increased pain sensitivity.[16] In special circumstances, when longer courses of opioid treatment may be required, an effort should be made to ensure close follow up as an outpatient. In addition, a patient may return to the ED for reassessment if 3 days of opioid treatment was inadequate and/or they were unable to arrange outpatient follow up within that time.

The benefits and safety of opioids for the management of chronic pain remain uncertain.[17-19] Treatment of chronic pain is complicated and requires a thorough assessment and determination of appropriate long-term therapy. Patients with chronic pain are optimally managed by a single long-term provider who can frequently monitor treatment efficacy and safety. Monitoring practices such as patient-prescriber agreements and urine drug testing are not practical in the emergency department setting.[20] Importantly, predictors for opioid abuse in chronic pain patients are difficult to assess during an emergency department evaluation.[11, 21]

Patients with a history of substance abuse are at an increased risk of opioid misuse when prescribed opioid analgesics for acute pain. The single question, "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?" was found to be 100% sensitive and 73.5% specific for the detection of a drug when the patient answered one or more times.[22] Consider alternative therapy in these patients.

Centralized prescription networks provide valuable information on a patient's prescription history. Multiple studies have shown that use of these systems leads to decreases in inappropriate prescribing practices.[23, 24]

Long acting opioids are high risk for respiratory depression and do not have a role in the treatment of acute pain syndromes.[25, 26] The pharmacokinetics of these medications result in an unpredictable peak effect and increase the risk of respiratory depression. Prescriptions for long acting and extended release opiates are more susceptible to diversion and non-medical opioid use.[26]

Consider other risk factors for respiratory depression such as obstructive sleep apnea. Prescribing new, or refilling old opioid prescriptions for patients already on opioids or sedative hypnotics have potential life threatening consequences due to respiratory depression and/or trauma secondary to mental status obtundation.

The EMTALA definition of a medical emergency makes reference to severe pain as a symptom that should be investigated; pain may be the result of an emergency medical condition. EMTALA does not state that severe pain is an emergency medical condition. EMTALA does not obstruct the emergency medical provider from applying their professional judgment to withhold opioid treatment of pain for ED patients without an emergency medical condition. [27]

Opioid dispensing and administration is fraught with it's own intrinsic problems and related morbidity and mortality. A thoughtful approach using this guideline provided will hopefully assist emergency physicians in treating pain ethically without the subsequent consequences associated with their administration.

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers 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 and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

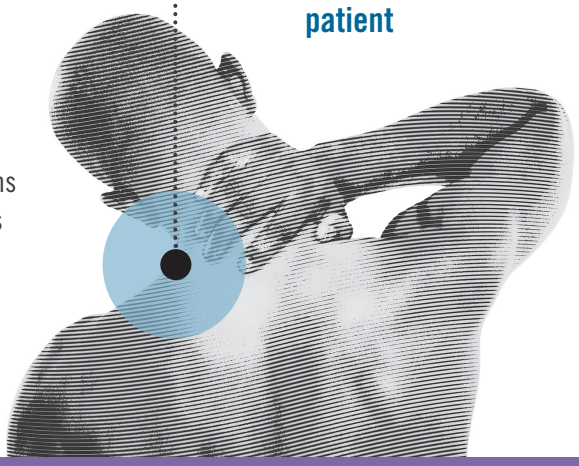
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



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

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

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

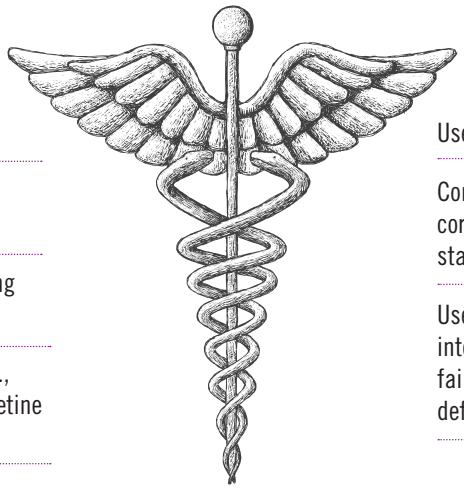
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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

NONOPIOID TREATMENTS FOR CHRONIC PAIN

PRINCIPLES OF CHRONIC PAIN TREATMENT

Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer. Effective approaches to chronic pain should:



- Use nonopioid therapies to the extent possible
- Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)
- Focus on functional goals and improvement, engaging patients actively in their pain management
- Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain)
- Use first-line medication options preferentially
- Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies
- Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

NONOPIOID MEDICATIONS

Medication	Magnitude of benefits	Harms	Comments
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First-line analgesic, probably less effective than NSAIDs
NSAIDs	Small-moderate	Cardiac, GI, renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants and serotonin/norephinephrine reuptake inhibitors	Small-moderate	TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small-moderate	Capsaicin initial flare/ burning, irritation of mucus membranes	Consider as alternative first-line, thought to be safer than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain

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

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

CS263451 March 14, 2016

RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

Low back pain

Self-care and education in all patients; advise patients to remain active and limit bedrest

Nonpharmacological treatments: Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

Medications

- First line: acetaminophen, non-steroidal anti inflammatory drugs (NSAIDs)
- Second line: Serotonin and norepinephrine reuptake inhibitors (SNRIs)/tricyclic antidepressants (TCAs)

Migraine

Preventive treatments

- Beta-blockers
- TCAs
- Antiseizure medications
- Calcium channel blockers
- Non-pharmacological treatments (Cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

Acute treatments

- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antinausea medication
- Triptans-migraine-specific

Neuropathic pain

Medications: TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine

Osteoarthritis

Nonpharmacological treatments: Exercise, weight loss, patient education

Medications

- First line: Acetamionphen, oral NSAIDs, topical NSAIDs
- Second line: Intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient)

Fibromyalgia

Patient education: Address diagnosis, treatment, and the patient's role in treatment

Nonpharmacological treatments: Low-impact aerobic exercise (i.e. brisk walking, swimming, water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

Medications

- FDA-approved: Pregabalin, duloxetine, milnacipran
- Other options: TCAs, gabapentin

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

Summary of

2015 Interagency Guideline on Prescribing Opioids for Pain

AMDG agency medical directors' group

A collaboration of state agencies, working together to improve health care quality for Washington State citizens.

See full guideline at
www.AgencyMedDirectors.wa.gov

All pain phases

- Use non-opioid therapies, such as behavioral intervention, physical activity and non-opioid analgesics.
- Avoid opioids if the patient has significant respiratory depression, current substance use disorder, history of prior opioid overdose or a pattern of aberrant behaviors.
- Assess and document function and pain using a validated tool at each visit where opioids are prescribed.
- Don't prescribe opioids with benzodiazepines, carisoprodol, or sedative-hypnotics.

Acute phase (0–6 weeks)

- Check the state's Prescription Monitoring Program (PMP) before prescribing.
- Don't prescribe opioids for non-specific back pain, headaches, or fibromyalgia.
- Prescribe the lowest necessary dose for the shortest duration.
- Opioid use beyond the acute phase is rarely indicated.

Perioperative pain

- Evaluate thoroughly preoperatively: check the PMP and assess risk for over-sedation and difficult-to-control pain.
- Discharge with acetaminophen, NSAIDs, or very limited supply (2–3 days) of short-acting opioids for some minor surgeries.
- For patients on chronic opioids, taper to preoperative doses or lower within 6 weeks following major surgery.

Subacute phase (6–12 weeks)

- Don't continue opioids without clinically meaningful improvement in function (CMIF) and pain.
- Screen for comorbid mental health conditions and risk for opioid misuse using validated tools.
- Recheck the PMP and administer a baseline urine drug test (UDT) if you plan to prescribe opioids beyond 6 weeks.

Chronic phase (>12 weeks)

- Continue to prescribe opioids only if there is sustained CMIF and no serious adverse events, risk factors, or contraindications.
- Repeat PMP check and UDT at frequency determined by the patient's risk category.
- Prescribe in 7-day multiples to avoid ending supply on a weekend.
- Don't exceed 120 mg/day MED without a pain management consultation.

over

When to discontinue

- At the patient's request
- No CMIF
- Risks outweigh benefits
- Severe adverse outcome or overdose event
- Substance use disorder identified (except tobacco)
- Aberrant behaviors exhibited
- To maintain compliance with DOH rules or consistency with AMDG guideline

Considerations prior to taper

- Help the patient understand that chronic pain is complex and opioids cannot eliminate pain.
- Consider an outpatient taper if the patient isn't on high-dose opioids or doesn't have comorbid substance use disorder or other active mental health disorder.
- Seek consultation if the patient failed previous taper or is at greater risk for failure due to high-dose opioids, concurrent benzodiazepine use, comorbid substance use disorder or other active mental health disorder.

How to discontinue

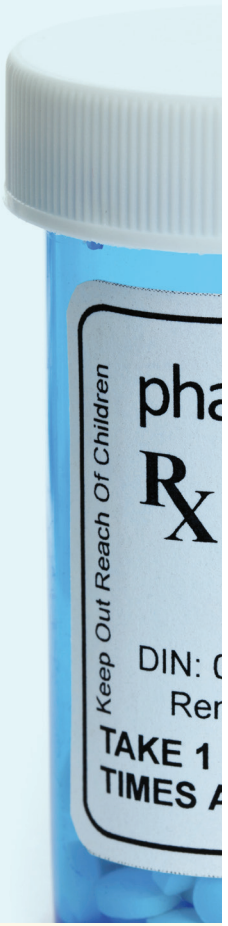
- Taper opioids first if patients are also on benzodiazepines.
- Unless safety considerations require a more rapid taper, start with 10% per week and adjust based on the patient's response.
- Don't reverse the taper; it can be slowed or paused while managing withdrawal symptoms.
- Watch for unmasked mental health disorders, especially in patients on prolonged or high-dose opioids.

Recognizing and treating opioid use disorder

- Assess for opioid use disorder and/or refer for a consultation if the patient exhibits aberrant behaviors.
- Help patients get medication-assisted treatment along with behavioral therapies.
- Prescribe naloxone (especially if you suspect heroin use) and educate patient's contacts on how to use it.

Special populations

- Counsel women before and during pregnancy about maternal, fetal, and neonatal risks.
- For children and adolescents, avoid prescribing opioids for most chronic pain problems.
- In older adults, initiate opioids at 25–50% lower dose than for younger adults.
- For cancer survivors, rule out recurrence or secondary malignancy for any new or worsening pain.



Check out the resources at
www.AgencyMedDirectors.wa.gov

- Free online CME
- Opioid Dose Calculator
- Videos from Primary Pain Care Conference

CLINICAL GUIDELINES FLOWCHART
for Evaluation and Treatment of Chronic Non-Cancer Pain

START

REVIEW MEDICAL & MEDICATION HISTORY

- ⇨ Review medical history, including records from previous providers before prescribing. Check CURES and UTox.
- ⇨ Do a physical exam to determine baseline function and pain.
- ⇨ What prior attempts were made to treat this pain with non-opioid modalities?
- ⇨ Is the diagnosis appropriate for opioid treatment? There is no evidence of benefit in chronic lower back pain, migraines, fibromyalgia, or neuropathy.
- ⇨ Prescribing chronic opioids is rarely appropriate on the first visit. Bridge with a few days' supply while documenting.
- ⇨ Do a psychosocial and risk assessment for medication abuse, e.g. Opioid Risk Tool (ORT) and Screener & Opioid Assessment for Patients with Pain (SOAPP). Screen for psychiatric co-morbidity.
- ⇨ Do a physical assessment for safety of opioid use, e.g., bone density, EKG, sleep study, testosterone level, and STOP BANG for sleep apnea.

GREEN LIGHT

INCORPORATE NON-OPIOID INTERVENTIONS

Create a plan of treatment with the patient that incorporates non-opioid interventions, such as:

- ⇨ Patient lifestyle improvement: Exercise, weight loss
- ⇨ Behavioral therapies: Cognitive Behavioral Therapy (CBT), peer-to-peer or other peer support, mindfulness training, psychotherapy, case management
- ⇨ Physiotherapy modalities: OT, PT, passive modalities
- ⇨ Medical interventions: Pharmacological, procedural, surgical
- ⇨ Treatment modalities: Acupuncture, massage

CAUTION

IF YOU DECIDE ON OPIOID TREATMENT: START LOW & GO SLOW

- ⇨ Counsel patients on potential risks. Agree on and document treatment goals. Patient signs informed consent and treatment agreement.
- ⇨ Check for evidence of possible misuse (CURES) and baseline urine screen.
- ⇨ Track medical and age-related conditions that increase risks of opioids.

REASESS

REASSESS EVERY 6 MONTHS

- ⇨ Evaluate progress toward treatment goals. If no improvement or progress on goals, stop and reassess. Use tools to assess for changes in function and pain: ORT, Tampa_Scale_for Kinesiophobia, or Current Opioid Misuse Measure (COMM) 1 to 2 x per year.
- ⇨ Assess for worrisome behaviors and side effects every six months.

STOP!

STOP!

- ⇨ Seek help from community partners, specialists, medical director, or review committee if you have:
  - Concerns from your visit assessment, or
  - Notice signs of significant misuse or illicit drug use.
- ⇨ Re-evaluate your treatment plan/seek help if the patient is at high risk of death. For example if prescribing:
  - More than 120 mg MED/day without functional improvement, or
  - Opioids with benzodiazepines, or
  - More than 40 mg of methadone/day.
- ⇨ Drug screen: Quarterly (standard) or more often (higher risk).

Alameda County Health Care Services Agency *adapted this from the Oregon Pain Guidance guidelines at www.oregonpainguidance.org.*
Find this flowchart at www.acgov.org/health/indigent/coalition.htm.

Senate Bill No. 482

Passed the Senate August 30, 2016

_____

Secretary of the Senate

Passed the Assembly August 24, 2016

_____

Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2016, at _____ o'clock ___M.

_____

Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 11165 and 11165.1 of, and to add Section 11165.4 to, the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 482, Lara. Controlled substances: CURES database.

Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, administer, furnish, or dispense these controlled substances. Existing law requires dispensing pharmacies and clinics to report specified information for each prescription of a Schedule II, Schedule III, or Schedule IV controlled substance to the department.

This bill would require a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance to consult the CURES database to review a patient's controlled substance history no earlier than 24 hours, or the previous business day, before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every 4 months thereafter if the substance remains part of the treatment of the patient. The bill would exempt a veterinarian and a pharmacist from this requirement. The bill would also exempt a health care practitioner from this requirement under specified circumstances, including, among others, if prescribing, ordering, administering, or furnishing a controlled substance to a patient receiving hospice care, to a patient admitted to a specified facility for use while on facility premises, or to a patient as part of a treatment for a surgical procedure in a specified facility if the quantity of the controlled substance does not exceed a nonrefillable 5-day supply of the controlled substance that is to be used in accordance with the directions for use. The bill would require, if a health care practitioner authorized to prescribe, order, administer,

or furnish a controlled substance is not required to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient pursuant to one of those exemptions, the health care practitioner to consult the CURES database before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every 4 months thereafter if the substance remains part of the treatment of the patient.

This bill would provide that a health care practitioner who fails to consult the CURES database is required to be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board. The bill would make the above-mentioned provisions operative 6 months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff, user support, and education, as specified.

This bill would also exempt a health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, from civil or administrative liability arising from any false, incomplete, inaccurate, or misattributed information submitted to, reported by, or relied upon in the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

Existing law requires the operation of the CURES database to comply with all applicable federal and state privacy and security laws and regulations. Existing law authorizes the disclosure of data obtained from the CURES database to agencies and entities only for specified purposes and requires the Department of Justice to establish policies, procedures, and regulations regarding the use, access, disclosure, and security of the information within the CURES database.

This bill would authorize a health care practitioner to provide a patient with a copy of the patient's CURES patient activity report if no additional CURES data is provided. The bill would also prohibit a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances from obtaining data from the CURES database.

The people of the State of California do enact as follows:

SECTION 1. Section 11165 of the Health and Safety Code is amended to read:

11165. (a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

(b) The Department of Justice may seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES. The department shall annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES.

(c) (1) The operation of CURES shall comply with all applicable federal and state privacy and security laws and regulations.

(2) (A) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, provided that patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to any third party, unless authorized by, or pursuant to, state and

federal privacy and security laws and regulations. The Department of Justice shall establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, operation, storage, disclosure, and security of the information within CURES, consistent with this subdivision.

(B) Notwithstanding subparagraph (A), a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances shall not be provided data obtained from CURES.

(3) In accordance with federal and state privacy laws and regulations, a health care practitioner may provide a patient with a copy of the patient's CURES patient activity report as long as no additional CURES data is provided and keep a copy of the report in the patient's medical record in compliance with subdivision (d) of Section 11165.1.

(d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the Department of Justice as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed, in a format specified by the Department of Justice:

(1) Full name, address, and, if available, telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) International Statistical Classification of Diseases, 9th revision (ICD-9) or 10th revision (ICD-10) Code, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(e) The Department of Justice may invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database. All prescriber and dispenser invitees shall be licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, in active practice in California, and a regular user of CURES.

(f) The Department of Justice shall, prior to upgrading CURES, consult with prescribers licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, one or more of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, and any other stakeholder identified by the department, for the purpose of identifying desirable capabilities and upgrades to the CURES Prescription Drug Monitoring Program (PDMP).

(g) The Department of Justice may establish a process to educate authorized subscribers of the CURES PDMP on how to access and use the CURES PDMP.

SEC. 2. Section 11165.1 of the Health and Safety Code is amended to read:

11165.1. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that practitioner the electronic history of controlled substances

dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(ii) A pharmacist shall, before July 1, 2016, or upon licensure, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that pharmacist the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES PDMP.

(B) An application may be denied, or a subscriber may be suspended, for reasons which include, but are not limited to, the following:

(i) Materially falsifying an application for a subscriber.

(ii) Failure to maintain effective controls for access to the patient activity report.

(iii) Suspended or revoked federal DEA registration.

(iv) Any subscriber who is arrested for a violation of law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.

(v) Any subscriber accessing information for any other reason than caring for his or her patients.

(C) Any authorized subscriber shall notify the Department of Justice within 30 days of any changes to the subscriber account.

(2) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 or a pharmacist shall be deemed to have complied with paragraph (1) if the licensed health care practitioner or pharmacist has been approved to access the CURES database through the process developed pursuant to subdivision (a) of Section 209 of the Business and Professions Code.

(b) Any request for, or release of, a controlled substance history pursuant to this section shall be made in accordance with guidelines developed by the Department of Justice.

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled

substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the Department of Justice pursuant to this section is medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to a prescriber or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code of Federal Regulations.

(f) A health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, is not subject to civil or administrative liability arising from any false, incomplete, inaccurate, or misattributed information submitted to, reported by, or relied upon in the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

SEC. 3. Section 11165.4 is added to the Health and Safety Code, to read:

11165.4. (a) (1) (A) (i) 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.

(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), 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) For purposes of this paragraph, "first time" means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall obtain a patient's controlled substance history from the CURES database no earlier than 24 hours, or the previous business day, before he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure and the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

(5) (A) If all of the following circumstances are satisfied:

(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

(iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient's medical record.

(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable five-day supply if the controlled substance were used in accordance with the directions for use.

(d) (1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

(e) This section is not operative until six months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in Schedule (6) of Item 0820-001-0001 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016), user support, and education. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

(f) All applicable state and federal privacy laws govern the duties required by this section.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

Approved _____, 2016

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Governor

Controlled Prescriptions: Questions and Answers

This section of the toolkit provides helpful prescribing tips and patient answers.

Safe Pain Medicine Prescribing in Emergency Departments:

Controlled Prescriptions: Questions and Answers

April 2014
Roneet Lev, MD

As physicians we feel the responsibility to be the ultimate patient advocate, the safety net, the one doctor who can fix things when no one else can. We are always there, 24/7, ready to solve problems. If patients can't get their prescriptions from their clinic, we are there to help. If the psychiatrist can't be reached and the patients need their medications, we are there. If medications are stolen, we are there.

Unfortunately, sometimes when we write prescriptions we are harming patients, not helping them. Prescription Drug Abuse is an epidemic with 105 lives lost per day nationwide according to the Centers of Disease Control. All of these deaths are preventable.

We prescribe 10 times more pills now than we did 10 years ago. There is a high street value for many of the controlled substances, and diversion of medications is a serious problem. We need to follow the Goldilocks rule: not too much, not too little, but just right. The quantities of pills need to help, without leftover for potential diversion or waste.

It is much harder to say no to patients than to say yes. The "Yes" doctors are quickly identified as the "candy man" in the community. The "Yes" emergency departments are the "candy land." Word gets out quickly.

Hopefully this article will help you to say "No," to do it in a nice way, and to realize that you are helping your patient with your decision. You are the ultimate patient advocate, and that is why you must prescribe safely.

These are general recommendations based on my experiences and those of my colleagues. I chair the prescription drug abuse medical task force in San Diego, with California ACEP, and work with the medical and community at large to curb the prescription drug abuse epidemic. You may like some suggestions and not others. That's not a problem. With time and practice you will develop the best language that works for you.

Helpful Prescribing Tips:

- CURES is your friend. It is a valuable tool, like checking old records. It makes you a better doctor. I had a patient who said, "I don't have a doctor." I checked CURES, and they did have a doctor. "Oh, that's not my doctor, that's just my pain doctor." You will also find out when patients really need a prescription and couldn't get it. CURES will help you prescribe smarter.

- There are many patient advocates who are appalled by the number of prescriptions that we write for. We generally hear the complaints when we do not give prescriptions that patients are demanding. However, there are an equal number of people who are angry that doctors are over-prescribing. "I can't believe that the doctor gave me 30 Percocet after a simple cyst was removed!" I have seen a prescription of Vicoprofen given after a dental cleaning! The prescription was given to the wife of a prescription drug abuse advocate. Now it is a permanent exhibit in the anti-drug lectures.

- Opioid withdrawal is uncomfortable, but not dangerous. New patients who present to the pain specialist are not immediately given whatever meds they state they need. The specialist first does research - CURES report, drug screen, reviews old records - and it may be 2 weeks before the patient is placed on a regular regimen. Do not feel badly if you are sending a patient home without a pain prescription in someone who has already received one in the past month from a different provider.

- Chronic Pain Medication refill principles are really the same for all patients. The underlying diagnosis does not matter - cancer, sickle cell anemia, spinal stenosis, fibromyalgia. If the patient has prescriptions from other doctors, then the ED should not be giving more prescription.

- Benzodiazepine withdrawal, unlike opioid withdrawal can be dangerous. Xanax is a frequently requested medication. However the half-life is short and abuse potential is high. According to the San Diego Coroner report, the deaths from Xanax equal the deaths from oxycodone. If you need to prescribe a benzodiazepine, give ativan or librium.

- For alcohol withdrawal, there is no point in writing a prescription for librium if the patient plans on continuing to drink. Ask the patient what his or her intention is. If they want to try and stop, then by all means, write a prescription. The alcohol treatment programs recommend that you write the prescription "prn", so if your patient goes to a treatment program it can be given as needed instead of round the clock. Usually no more than 10 pills are needed.

- If a patient already has pain pills at home, they usually do not need more pills from you. A patient with a kidney stone or humerus fracture, who already is on Percocet for back pain, usually does not need extra pills. Treat the acute pain in the ED/Urgent Care Centers, but the patient may not need another prescription.

- Patients on chronic pain medications should have a pain contract with their doctor. Chronic pain means needing opioids for 3 months or more. The Medication Agreement states that medications will not be refilled in the emergency department/urgent care centers, that lost prescriptions will not be refilled, and that the patient should make appointments with his or her doctor before he or she runs out of their medication. Having such a patient come to the ED for a prescription is like a child asking the mother for permission to go out after the father said no. (For my kids this is a crime with the highest level of punishment). You are not helping the patient by filling such a prescription.

- Patients should not mix opioids and benzodiazepines. Patients should not mix opioids with illegal drugs. Pain specialists as part of their practice make patients choose between opioids and benzodiazepines. There are unfortunate patients who have a legitimate pain condition, but refuse to stop abusing meth or heroin, and therefore the clinics will not refill pain prescription. Giving a controlled prescription to a patient who is a known addict is a DEA violation and can jeopardize your license.

- Don't prescribe Soma (Carisoprodol). This is a highly abused medication that is suppose to work as a muscle relaxant, but in fact is metabolized to meprobamate, a horse tranquilizer that is no longer available in Canada, Sweden, and Norway. If you are prescribing a muscle relaxant, use Flexeril (cyclobenzaprine) instead. Soma is part of the "Holy Trinity": Oxycodone, Xanax, and Soma. Some pharmacies have a red flag warning to call a physician for a written justification for all patients on the "Holy Trinity." It's much easier to just not write for Soma than to fill out paperwork explaining why the patient needs it.

- In a hurry? Don't want confrontation? It is a lot easier to say "yes" and just give a few pills. It is much harder to say "no", look at CURES and check prior records. How bad can a few pills be? A few pills can mean continued addiction, drug diversion, avoiding getting help, and even death. The yes doctor is the "candy man." You need to follow the well know rule of medicine: "Physician do no harm".

Helpful Patient Answers

PATIENT COMPLAINT: "Back Pain or Headache with multiple previous visits."

PROVIDER ACTION: "Listen carefully; get a full history, physical, and medication history."

Don't make the mistake of jumping to conclusions because the patient is there again and again for the same complaint. Don't start rolling your eyes and label the patient a "drug seeker."

The first thing to do is to treat this patient like any other patient. EMTALA mandates that even if a patient presents with a chronic condition, you need to do a full screening to make sure the patient does not have an emergency medicine condition. Sit down, take a good history and include a very detailed medication history. Do a thorough physical examination. Check the old chart. Do your homework even more than you would a different patient. See if something was missed on previous visits.

I am sure you have seen a patients like this example. Chief complaint: "headache," and the nurses said "he is here all the time - he just wants drugs." I smiled, thanked them for the heads up, put blinders on to what was implied, and took the time to do a careful assessment. This patient was in hospital a month ago for headache with a negative work up. There was an explanation of why the admitting team did not think an LP was warranted. Teaching point - someone didn't want to do a test that = I have to do it. And of course, this man had meningitis. Not just any meningitis, but TB meningitis. We all know that revisits to the ED/urgent care centers are opportunities to find the real diagnosis.

PATIENT REQUEST: "Can I have something for pain?"
This is a common request from many patients with various chief complaints.

PROVDIER ANSWER: "Yes, let me check your medical record for the best choice."
You will generally offer pain medications to many patients before they even ask. You may not need the part about "let me check your records." Even with patients who are drug seeking, you will often want to offer pain relief, even if it is a non-opioid choice. Then go to the chart, to CURES, and do some research for the best plan.

PATIENT REQUEST: A patient requests a pain prescription when medical records or CURES show that they already receive a prescription from a different provider.

PROVIDER ANSWER: "I will treat your pain now, but your doctor needs to write for any additional prescriptions."
"I see that you already have prescriptions from Dr. X. For your safety all of your pain medications need to be regulated by a single doctor and pharmacy." **Although I cannot write for a pain prescription, I can certainly help with your pain today."**

Usually that does the trick. However if you need, you can use the following lines:

"These medications are controlled by the DEA, which has strict rules for both the doctor and the patient. You have to get any new prescriptions from your doctor or clinic."

"**We practice safe medicine and therefore all prescriptions and care should be coordinated with your doctor."**

And finally, you can simply say**, "I am sorry, we follow the safe prescribing guidelines, which means all your narcotic prescriptions have to come from one doctor and one pharmacy."**

PATIENT COMMENT: "But my doctor is out of town, my insurance changed, I couldn't get an appointment"

PROVIDER ANSWER: "I'm sorry that happened. We can help you with your pain in the emergency department/urgent care center, but for your safety you will need to contact your doctor for any additional prescriptions."
Like with talking to small children, try to avoid the word, "no", and make statements in the positive.

Look at the CURES report. You will see if the patient has received medications from the same clinic on a monthly basis. If this is the case, then it should be part of their pain contract not to get additional prescription from the ED/Urgent Care Center. If the patient is doctor shopping, then you should not be part of that.

"Your doctor would want us to honor the pain contract, so I would want to follow your doctor's recommendations."

I have had a patient tell me "But I made sure I did not sign the contract, so that I can get more medication." Well... just because she didn't sign it doesn't mean we should not be following the pain contract.

PATIENT COMPLAINT: "None of the other medicines work for me"
Patients frequently say, "I tried ibuprofen", "I tried Vicodin", and "Those don't work for me. What I really need is Dilaudid 2 mg IV with Benadryl 50 mg and Phenergan."

PROVIDER ANSWER - "Can you please tell me how you take the prescription?"
There are some reasonable patients who really tried the ibuprofen and Vicodin, but you need to find out exactly how they used it.

You need to ask: **"Tell me how are you taking your medication."** Find out the dose and the timing.

You will be surprised how many patients used 400 mg of ibuprofen twice a day and it was not enough. Or they took one pill of Vicodin last night and now 8 hours later they are in the ED/Urgent Care Center with pain again without taking anything in between.

Depending on the description of how the medications are being taken, your answer could be: "**That's the right dosing**, good job, you should continue." Or "**That's not quite giving the medications a chance to work**. Let's try having you take the medication with a good dose. If you take Vicodin 4 times a day and add ibuprofen 4 times a day, you can alternate and have something to take 8 times a day. The combination works well."

The unreasonable patient will give you a vague answer like: "I have tried it in the past, so I know it doesn't work," or "I am allergic to everything." This is a red flag for you to check CURES and old records. The answer is: **"I need to review your records to find out what the best options are."** Go to the records, do the research, find out the allergies and what they received before, and return with a plan.

PATIENT COMPLAINT: "My prescriptions were lost"
Patients will come to the ED/Urgent Care Centers and ask for a refill of a prescription because they lost it. We have heard all the reasons: "I forgot them on the bus," "My back pack was stolen," " I flushed them down the toilet because I thought I didn't need them," "they fell in the pool," and "I lost them at Disneyland."

PROVIDER ANSWER: "I can give you something for pain now, but it is best for your doctor to coordinate any additional prescription."
If the patient says that the prescriptions were stolen, then the answer is easy:
"Did you file a police report?" These are highly abused medications that are sold illegally. If a prescription were stolen then the DEA or police would want to know about it.

With a lost or stolen prescription, you need to listen to the story and use your judgment. Pain Agreements state that patients should not lose their medications and keep them safe. Some pain agreements allow for one lost prescription a year. The primary care doctor should be aware of the missing prescription. It is probably best to have lost or stolen prescriptions refilled by the primary care provider who can take account of all the prescriptions. Check a CURES report and see if there is a bigger problem.

Make sure that you document on the patient's discharge instructions and in your dictation: **"Please obtain all pain medications from single doctor or clinic. No refills will be provided by the emergency department/urgent care center."** This should be a message for doctors coming after you that the patient has received information on safe prescribing.

PATIENT QUESTION: "I need some codeine for my cough."

Phenergan with codeine cough syrup is a highly abused medication. There are cultures that put this medication in their drink and sip it all day. There have been pharmacies in some parts of town that received a fine for excessive loads of Phenergan with codeine. I've seen funny hidden camera videos showing pharmacy techs sneaking sips of codeine while at work.

PROVIDER ANSWER: "The best medicine for your cough is an inhaler."
"The inhaler opens your lungs and gets the junk out. A cough syrup just prevents the cough reflex and keeps the junk in. That's why I don't prescribe the cough syrup and use the inhaler instead".

PATIENT QUESTION: "My tooth hurts."

PROVIDER ANSWER: "Would you like a shot to stop the pain?'

One of my favorite patients is a dental patient, and not because my husband is a dentist. It's because these are the most grateful patients. Do a dental block with Marcaine and get 100% relief for 6 hours. When I ask "Do you want a shot like the dentist for your pain that will numb up your tooth?" Patient with true dental pain will say: "Anything, just get rid of the pain." You should never give an IM injection of Dilaudid for dental pain. If the patient is "scared" of a shot (dental block), then you can offer a couple Vicodin in the ED/urgent care and check a CURES report to see if you should be writing a prescription or not.

PATIENT QUESTION: "I know my rights!"
There are patients who are angry no matter what we do or how nice we are. They threaten to sue you and want to talk to a manager.

PROVIDER ANSWER: "I am happy to refer you to our manager."
Remember that you are on stage when you talk to patients. Your conversation is not just for the patient, but also for the big audience of other patients and staff who are listening in on the interesting loud interaction. The listeners want to root for you.

I have used the same language to one patient who is so thankful that someone took the time to explain the dangers of the medications, and another who gets angry and called administration.

If you are referring the patient to hospital administration, hopefully they understand and are educated about safe prescribing. If not, you should provide some educational background and refer them to the various web sites that explain the prescription drug abuse epidemic and safe prescribing. (CaliforniaACEP.org or SanDIegoSafePrescribing.org).

There are several lines you can use in difficult situations:

"I am sorry you feel this way, and I am happy to refer you to our manager."
"This is the same treatment I give my own family."

PATIENT MEDICATION HISTORY: " Vicodin, Ambien, Xanax, Soma, Neurontin, ..."

PROVIDER ANSWER: "I see that your medications have some drug interactions."
I am sure you have reviewed patient medication lists that go on for pages. Use this as an opportunity to alert the patient to polypharmacy or for opioid and sedative interactions. A patient may present with a fall, but the fall is because of all the medications.
"Wow, that's a long list of medications!"
"I see from the list that you are taking pain medications and anxiety medications together. That could be a dangerous combination."
"I don't want to make changes to your medications, but you should discuss this with your doctor, and at least do not take the oxycodone and xanax at the same time."
"You seem very sleepy from these medications."

"Could it be that you fell down because of your medications?"
One family member of a patient I saw agreed with my explanation and said, "We don't want a Michael Jackson."

PATIENT PRESENTATION: Abdominal pain with multiple negative work ups.
PROVIDER ANSWER: "How often do you use marijuana?"

The first thing to do is a good history, physical, and make sure that a different diagnosis has not been overlooked. After that, think marijuana.

Marijuana these days is not the marijuana of the 1970s. California marijuana can have 25% THC or more, while in the 70's marijuana was 3% THC. There is a new surge of chronic abdominal pain patients who have had multiple CT scans, endoscopies, colonoscopies, and ultrasounds, all with negative results, but with a history of daily marijuana use. The treatment for THC associated cyclic vomiting syndrome is to get off the marijuana, and not to get more and more Dilaudid. Treating marijuana toxicity with opioids is creating a second addiction on top of the first one. This is difficult to explain to patients, because they were told marijuana helps nausea rather than causing it. If you can convince the patient to stop marijuana for several months (not just a few days), they will be grateful later.

PATIENT PRESENTATION: Musculoskeletal pain in a Patient who is in recovery.

PROVIDER ANSWER: "You did such a good job being clean, it's not a good idea to trade one drug for another."
You see patients in recovery that is proud of their recovery, but have a new pain condition. They understand addiction. Explain to them that using Motrin and Tylenol and limiting opioids will help them prevent a new addiction.

PATIENT COMPLAINT: Pain

PROVIDER DISCHARGE INSTRUCTION: "I will give you a prescription for Norco. Please realize that this is a medication that can be abused. Keep it secure, take it only as prescribed, and do not drive if not fully alert."

The prescription drug abuse advocates request that physicians warn their patients about the seriousness of controlled medications. A quick warning in the ED can go a long way.

PATIENT PRESENTATION: Clear Doctor Shopping

PROVIDER ANSWER: "I am concerned as your medications can be addicting. Would you like me to refer you to someone who can help with this?"

As with everything, you have to use your judgment. Most patients who are in the ED/Urgent Care Center are not ready to admit that they have an addiction, but sometime their family members are around and realize that there is a problem. **Use family and friends to highlight a prescription problem.**

This is the language recommended for the primary care provider when they need to discontinue opioid treatment because of prescription drug abuse: **"The medication no longer appears to be as beneficial as it once was. As the benefits of the opioids no longer outweigh the risks, we need to discontinue this approach and together find a safer and more effective means of dealing with your pain".**

Some patients have very overt doctor shopping and you may want to contact the DEA. Getting the DEA involved can force patients into court mandated drug rehab and save someone's life.

Words at a Glance

PATIENT	PROVIDER ANSWER
Anything	**Remember you are on stage. Your words not just for the patient, but for the staff and patients who are also listening.**
Can I have something for pain?	**"Yes, let me check your medical record for the best choice"**
The medicines don't work	**"Can you please tell me how you take the prescription?"**
Lost Rx Rx from other Sources	**I can give you something for pain now, but it is best for your doctor to coordinate any additional prescription".**
Stolen Rx	**Did you file a police report?**
Patient with chronic pain	**"Your doctor would want us to honor the pain contract, so I would want to follow your doctor's recommendations".**
I need codeine cough syrup	**"The best medicine for your cough is an inhaler.**
Dental Pain	**"Would you like a shot to stop the pain?'**
Abdominal Pain with negative work ups	**"How often do you use marijuana?"**
Previous Recovery History	**"You did such a good job being clean, it's not a good idea to trade one drug for another".**
Opioids and Sedatives	**"I see that your medications have some drug interactions"**
Clear Doctor Shopping	**"I am concerned as your medications can be addicting. Would you like me to refer you to someone who can help with this?"**
Angry Patient	**"I am sorry you feel this way. I will try to treat your pain now, but your doctor needs to coordinate any further prescriptions."**

Further Suggestions

Medscape has a free CME program on "Managing Pain Patients Who Abuse Prescription Drugs." This has video examples of how a primary care provider talks to his patient. You will need a Medscape username and password. www.medscape.org/viewarticle/770440

If you have further tips and suggestions that should be included in the next version of this document, please contact Roneet Lev via email at roneet@cox.net.

Patient Materials

This section of the toolkit provides patient materials and instructions and recommendations for printing handouts and posters

- Instructions/Recommendations for printing Handouts and Posters
- Recommendations on the Use of the Patient Handout
- Patient Handouts for Urgent Care Centers (English and Spanish)
- Patient Handouts for Emergency Departments (English and Spanish)

Safe Pain Medication Prescribing in Emergency Departments & Urgent Care Centers

Recommendations on the Use of the *Safe Pain Medicine Prescribing* Patient Handout and Poster (English/Spanish)

The patient handout has been endorsed by Safe Med LA, with the support and endorsement of the following sponsor organizations, as well as others:

- LA County Department of Health Services
- LA County Department of Public Health
- California Chapter of the American College of Emergency Physicians
- Los Angeles County Medical Association
- Hospital Association of Southern California
- Kaiser Permanente

It has been adopted by all emergency departments in Los Angeles County and is already in use in Urgent Care Centers across Kaiser Permanente, several LA County Department of Health Services, and in San Diego and Imperial Counties. **We ask that every Emergency Department and Urgent Care Center/Clinic adopt the same patient communications to establish consistency across the County, which can mitigate doctor shopping and establish a shared standard of practice.**

The document has undergone a health literacy test and reads at a sixth-to-seventh-grade level and is available in English and Spanish.

When to Distribute Handouts:
We ask that every Emergency Department and/or Urgent Care Center/Clinic provide a copy of this flyer to every adult and appropriate adolescent patient prior to discharge. If not to "every" patient, we recommend this handout be given to every patient already on opioid prescription medications and/or patients who are prescribed opioids or being managed for pain.

We recommend your Emergency Department and/or Urgent Care Center/Clinic **establish a policy and procedure** to establish the process as a regular part of workflow, e.g., at registration, at discharge, by nursing staff or MDs, as part of the after visit summary, etc.

How to Distribute Handouts:
We recommend the use of the following script.
Health Care Provider: "Here is a flyer with information about the rules that our Emergency Department / Urgent Care Center/Clinic follows about pain medicine."

Posting Patient Handout in Emergency Department and Urgent Care Waiting Rooms and/or Exam Rooms

URGENT CARE CLINICS: We recommend that printed copies of the patient handout be posted throughout the Emergency Department and/or Urgent Care Center/Clinic, e.g., in waiting rooms and/or examination rooms, nurses stations, where they can be viewed by staff, as well as patients. *Since Urgent Care Centers/Clinics that are not part of Emergency Departments are not governed by EMTLA rules, posting of this information for patients in these settings is acceptable.*

EMERGENCY DEPARTMENTS: Due to current EMTLA rules, posting of this information in ED waiting rooms is not recommended. (See EMTLA Section 5.) Rather, the patient handout can and should be posted in examination rooms and nurses stations, where they can be viewed by staff, as well as patients.

How to Print Handouts and Posters:
A PDF of this handout is available on our website: www.SafeMedLA.org

- **Handouts** can be printed as 8 ½" x 11", Double-sided (English on one-side and Spanish on the other). Handouts should be printed in color for best results.

- **Posters**: For posting in waiting/exam rooms, you can print English and Spanish, and enlarge to document for posting.

SAFE PAIN MEDICINE PRESCRIBING

IN URGENT CARE CENTERS

We care about you. Our goal is to treat your medical conditions, including pain, effectively, safely and in the right way.

Pain relief treatment can be complicated. Mistakes or abuse of pain medicine can cause serious health problems and death.

Our Urgent Care will only provide pain relief options that are safe and correct.

For your SAFETY, we follow these rules when helping you with your pain.

1. We use our best judgment when treating pain. These recommendations follow legal and ethical advice.
2. You should have only ONE provider and ONE pharmacy helping you with pain. We do not usually prescribe pain medication if you already receive pain medicine from another health care provider.
3. If pain prescriptions are needed for pain, we will only give you a limited amount.
4. We do not refill stolen prescriptions. We do not refill lost prescriptions. If your prescription is stolen, please contact the police.
5. We do not prescribe long acting pain medicines such as: OxyContin, MSContin, Fentanyl (Duragesic), Methadone, Opana ER, Exalgo, and others.
6. We do not provide missed doses of Subutex, Suboxone, or Methadone.
7. We do not usually give shots for flare-ups of chronic pain. Medicines taken by mouth may be offered instead.
8. Health care laws, including HIPAA, allow us to ask for all of your medical records. These laws allow us to share information with other health providers who are treating you.
9. We may ask you to show a photo ID when you receive a prescription for pain medicines.
10. We use the California Prescription Drug Monitoring Program called CURES. This statewide computer system tracks opioid pain medications and other controlled substance prescriptions.

If you need help, please call 2-1-1 and ask for information on treatment services for drug use disorders.

Urgent Cares throughout Los Angeles County have agreed to participate in this important program.

To discuss safer and more helpful chronic pain treatment options, please schedule an appointment with your treating physician.

County of Los Angeles Public Health

Health Services Los Angeles County

California ACEP American College of Emergency Physicians

Los Angeles County Medical Association

Hospital Association of Southern California

Kaiser Permanente

ADMINISTRACIÓN DE MEDICAMENTOS PARA EL DOLOR

EN LAS CLINICAS DE URGENCIA

Nos preocupamos por su salud y bienestar y por lo mismo, nuestro objetivo es tratar sus condiciones médicas—incluyendo el dolor que sienta—de una manera eficaz, segura y adecuada.

El tratamiento para aliviar el dolor puede ser complicado. Los errores o el abuso de medicamentos con receta para lidiar con el dolor pueden provocar graves problemas de salud y hasta la muerte.

Nuestro clinica le proporcionará únicamente opciones de alivio del dolor que sean seguras y adecuadas.

Por su salud, siempre que le brindemos ayuda para lidiar con su dolor, seguiremos estas medidas de seguridad:

1. Usamos nuestro mejor criterio para tratar el dolor. Estas recomendaciones siguen consejos legales y éticos.
2. Nos aseguramos que tenga UN solo proveedor y UNA sola farmacia que le ayuden con su dolor. Normalmente no le recetaremos medicamentos para el dolor si usted ya recibe un medicamento contra el dolor de otro proveedor médico.
3. Si necesita un medicamento recetado para lidiar con su dolor, le daremos una cantidad limitada.
4. No surtimos recetas que fueron robadas ni recetas perdidas. Si le roban su receta de un medicamento contra el dolor, por favor póngase en contacto con su proveedor médico, la policía o el sheriff.
5. No recetamos medicinas para el dolor crónico como: OxyContin, MSContin, Fentanyl (Duragesic), Metadona, Opana ER, Exalgo entre otros.
6. No surtimos dosis perdidas de Subutex, Suboxona ni de Metadona.
7. No solemos proveer inyecciones de alivio rápido para el dolor crónico agudo. De intensificarse el dolor, es posible que se le ofrezca un medicamento oral.
8. Las leyes de protección a la salud, entre ellas HIPAA, nos dan acceso a su expediente médico. Estas leyes nos permiten compartir información con otros proveedores médicos que le brindan atención médica.
9. Podemos pedirle que nos muestre una identificación con fotografía cuando reciba un medicamento recetado para el dolor.
10. Usamos el programa *Controlled Substance Utilization Review and Evaluation System* (CURES en inglés), un sistema electrónico estatal que nos permite tener precaución y monitorear la frecuencia con la cual se receta un medicamento opioide para el dolor entre otras sustancias controladas.

Si necesita ayuda, por favor llame al 211 y pida información sobre los servicios de tratamiento para los trastornos por consumo de drogas.

Las clinicas de ugencia del Condado de Los Ángeles han aceptado participar en este importante programa.

Si desea aprender más sobre sus opciones para lidiar con el dolor crónico de una manera más segura y eficaz, hable con su médico de cabecera acerca de los tratamientos disponibles.

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SAFE PAIN MEDICINE PRESCRIBING
IN EMERGENCY DEPARTMENTS

We care about you. Our goal is to treat your medical conditions, including pain, effectively, safely and in the right way.

Pain relief treatment can be complicated. Mistakes or abuse of pain medicine can cause serious health problems and death.

Our emergency department will only provide pain relief options that are safe and correct.

For your SAFETY, we follow these rules when helping you with your pain.

1. We look for and treat emergencies. We use our best judgment when treating pain. These recommendations follow legal and ethical advice.
2. You should have only ONE provider and ONE pharmacy helping you with pain. We do not usually prescribe pain medication if you already receive pain medicine from another health care provider.
3. If pain prescriptions are needed for pain, we will only give you a limited amount.
4. We do not refill stolen prescriptions. We do not refill lost prescriptions. If your prescription is stolen, please contact the police.
5. We do not prescribe long acting pain medicines such as: OxyContin, MSContin, Fentanyl (Duragesic), Methadone, Opana ER, Exalgo, and others.
6. We do not provide missed doses of Subutex, Suboxone, or Methadone.
7. We do not usually give shots for flare-ups of chronic pain. Medicines taken by mouth may be offered instead.
8. Health care laws, including HIPAA, allow us to ask for all of your medical records. These laws allow us to share information with other health providers who are treating you.
9. We may ask you to show a photo ID when you receive a prescription for pain medicines.
10. We use the California Prescription Drug Monitoring Program called CURES. This statewide computer system tracks opioid pain medications and other controlled substance prescriptions.

If you need help, please call 2-1-1 and ask for information on treatment services for drug use disorders.

Emergency Departments throughout Los Angeles County have agreed to participate in this important program.

To discuss safer and more helpful chronic pain treatment options, please schedule an appointment with your treating physician.

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ADMINISTRACIÓN DE MEDICAMENTOS PARA EL DOLOR

EN LA SALA DE EMERGENCIAS

Nos preocupamos por su salud y bienestar y por lo mismo, nuestro objetivo es tratar sus condiciones médicas—incluyendo el dolor que sienta—de una manera eficaz, segura y adecuada.

El tratamiento para aliviar el dolor puede ser complicado. Los errores o el abuso de medicamentos con receta para lidiar con el dolor pueden provocar graves problemas de salud y hasta la muerte.

Nuestro departamento de emergencias le proporcionará únicamente opciones de alivio del dolor que sean seguras y adecuadas.

Por su salud, siempre que le brindemos ayuda para lidiar con su dolor, seguiremos estas medidas de seguridad:

1. Determinamos y tratamos emergencias. Usamos nuestro mejor criterio para tratar el dolor. Estas recomendaciones siguen consejos legales y éticos.
2. Nos aseguramos que tenga UN solo proveedor y UNA sola farmacia que le ayuden con su dolor. Normalmente no le recetaremos medicamentos para el dolor si usted ya recibe un medicamento contra el dolor de otro proveedor médico.
3. Si necesita un medicamento recetado para lidiar con su dolor, le daremos una cantidad limitada.
4. No surtimos recetas que fueron robadas ni recetas perdidas. Si le roban su receta de un medicamento contra el dolor, por favor póngase en contacto con su proveedor médico, la policía o el sheriff.
5. No recetamos medicinas para el dolor crónico como: OxyContin, MSContin, Fentanyl (Duragesic), Metadona, Opana ER, Exalgo entre otros.
6. No surtimos dosis perdidas de Subutex, Suboxona ni de Metadona.
7. No solemos proveer inyecciones de alivio rápido para el dolor crónico agudo. De intensificarse el dolor, es posible que se le ofrezca un medicamento oral.
8. Las leyes de protección a la salud, entre ellas HIPAA, nos dan acceso a su expediente médico. Estas leyes nos permiten compartir información con otros proveedores médicos que le brindan atención médica.
9. Podemos pedirle que nos muestre una identificación con fotografía cuando reciba un medicamento recetado para el dolor.
10. Usamos el programa *Controlled Substance Utilization Review and Evaluation System* (CURES en inglés), un sistema electrónico estatal que nos permite tener precaución y monitorear la frecuencia con la cual se receta un medicamento opioide para el dolor entre otras sustancias controladas.

Si necesita ayuda, por favor llame al 211 y pida información sobre los servicios de tratamiento para los trastornos por consumo de drogas.

Todos los departamentos de emergencia del Condado de Los Ángeles han aceptado participar en este importante programa.

Si desea aprender más sobre sus opciones para lidiar con el dolor crónico de una manera más segura y eficaz, hable con su médico de cabecera acerca de los tratamientos disponibles.

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Kaiser Permanente

Safe Prescribing Implementation

This section of the toolkit provides guidelines for safe prescribing.

- Implementation Checklist for Los Angeles County
- Talking Points for Discussions with CMOs, CNOs, and CEOs

Safe Prescribing Guidelines for Emergency Departments and Urgent Care Centers Implementation Checklist

Each emergency department and urgent care center may take a slightly different approach towards implementation of the Safe Prescribing Guidelines. However, in general, implementation may involve the following core activities:

Obtaining Buy-in and Formal Endorsement
While it may vary, the following are the key steps towards getting the guidelines adopted within a hospital environment:

- ❑ Departmental meeting(s) to review the Safe Prescribing Guidelines, obtain buy-in from frontline clinical staff, and address any potential clinical concerns

- ❑ Upon departmental endorsement, formal endorsement of the Safe Prescribing Guidelines by the medical staff (usually through the Medical Executive Committee or similar leadership group)

- ❑ Upon endorsement, formal approval by the hospital CEO or designee, as needed,

Clinics, medical groups, and other types of organizations may have a similar, albeit less formal, process. Whichever process is used to endorse the guidelines, it is important to ensure the process promotes buy-in from clinical staff.

Educating Patients at the Point of Care
We ask that every emergency department and urgent care center provide a copy of the guidelines to patients at discharge. This can be part of the general discharge instructions given to patients. You may also use the handout after doing a medical screening evaluation (MSE) on selected patients as needed. It is important that the guidelines be uniform and consistent across EDs and urgent care centers, but the format and medium in which the guidelines are distributed is up to the discretion of each facility. It is also important that the guidelines be widely disseminated to patients, but whether this includes all ED/urgent care patients or a subset of patients is also up to the discretion of each facility.

- ❑ Incorporate guidelines into your EMR to be included on discharge instructions
  - ❖ Electronic copies of the flyer can be downloaded from www.SafeMedLA.org

- ❑ Have printed flyers available at the point of care to provide to patients upon discharge or after doing an MSE
  - ❖ Electronic copies of the flyer can be downloaded from www.SafeMedLA.org
  - ❖ Follow these guidelines when printing handouts:
    - Final printed size of handouts is 5½" x 8½", with English on one side Spanish on the other
    - If you print on 8½" x 11", place two copies of the guidelines on each side and cut in half for two copies
    - Paper type should be 80# gloss coated book

- ❑ Educate physicians and clinical staff about how to appropriately distribute the Safe Prescribing Guidelines
  - ❖ Physicians and clinical staff can use the following script: "Here is a flyer/information about the rules that our emergency department follows about pain medicine."
  - ❖ Emergency Departments should not risk an EMTALA violation – only provide guidelines after an MSE is completed. **THIS IS NOT AN ISSUE IN URGENT CARE CLINCS, which can provide the patient information in the waiting room, on registration, during patient visit, or upon discharge..**

    All patients who present to the ED should have a medical screening examination to determine if an emergency medical condition exists, if one is found stabilizing treatment must be provided. Any information regarding an ED's policy about controlled substances, such as brochures should

only be given to the patient after the medical screening examination has been completed. Since posters, even if located in patient treatment rooms, may be seen prior to the MSE being completed, posters may risk EMTALA noncompliance. For more information about EMTALA concerns, visit: http://californiaacep.org/wp-content/uploads/Safe-Prescribing-FAQ.pdf .

- ❖ Share CalACEP's script on "How to Talk to Your Patients about Safe Prescribing" (available at www.EastBaySafeRx.org)

Engaging the Broader Medical Staff and Clinical Staff

To ensure there is broad awareness of the guidelines among the physicians and clinical staff, each hospital and urgent care center is asked to engage in educational activities with physicians and clinical staff to help build awareness and knowledge of the guidelines beyond emergency departments and urgent care centers. Activities may include:

- ❑ Arrange presentations at medical staff meetings, grand rounds and departmental meetings
- ❑ Publish an article and a copy of the guidelines in newsletters
- ❑ Promote greater awareness about best practices in pain management and opioid prescribing, including topics such as: managing chronic pain patients on extended release/long acting opioids; updated Medical Board of California guidelines for pain management; etc.
  - ❖ Clinical resources for physicians and clinicians can be accessed from www.SafeMedLA.org
- ❑ Promote utilization of the CURES Prescription Drug Monitoring Program whenever prescribing opioids
  - ❖ NOTE: All California licensed physicians who prescribe controlled substances are required to enroll in CURES by July 1st, 2016
  - ❖ Instructions and information on registering for CURES can be accessed from www.SafeMedLA.org
  - ❖ Consider conducting a survey to track the number of physicians on your medical staff who are enrolled in CURES and the frequency of utilization when prescribing opioids.

Educating the Public

To promote awareness of the guidelines community-wide, hospitals and urgent care centers are asked to utilize their patient communications channels to inform the public about the guidelines. Activities may include:

- ❑ Place an announcement in your patient newsletter announcing your participation in the SafeMedLA Safe Prescribing Coalition and your endorsement of the guidelines
- ❑ Publish a press release announcing the guidelines
- ❑ Educate patients through other mediums as appropriate (hosting educational programs, publicizing the guidelines in public spaces outside of the ED, etc.)

Track Your Efforts

Please use this checklist to keep help track of your efforts to implement the Safe Prescribing Guideline. The Safe Med LA Coalition will be surveying participating emergency departments and urgent care centers periodically to gauge implementation activities and solicit feedback on how we can better support your efforts.

Safe Pain Medicine Prescribing in Emergency Departments and Urgent Care Centers:

Talking Points for Discussions with CMOs, CNOs and CEOs

As you implement the Safe Pain Medication Prescribing guidelines in your ED / Urgent Care Center, you may need to have a discussion with the CMO, CNO or CEO of your institution. They may have concerns regarding EMTALA, the Joint Commission or Patient Satisfaction. We summarize the key points about these key issues below.

Background on the Opioid Epidemic in the United States The United States is experiencing a major problem with prescription opioids. Opioid prescriptions have increased across the country and deaths from opioid overdoses have increased right along with it. Physicians need to do our share to curtail this problem. Safe Pain Medication Prescribing guidelines state that a patient with chronic pain should have one provider who can safely administer high risk pain medications that have the potential for addiction or diversion to other people. This means that Emergency Departments and Urgent Care centers must focus on supporting that by not refilling high risk medications like opioids, not rewriting for lost or stolen prescriptions, and not prescribing long-acting opioid medications among other things.

EMTALA The Emergency Medical Treatment and Active Labor Act (EMTALA) mandates that all patients arriving to an Emergency Department receive a medical screening examination. This includes patients with chronic pain. Pain is a potential sign of an emergency medical condition that must be considered when a provider performs a medical screening examination. EMTALA does not regulate nor mandate the actual treatment of pain. EMTALA only mandates the evaluation of pain as a possible symptom of an emergency medical condition. (A) Recently, CMS provided an opinion on the hanging of signs in triage areas describing safe pain medication prescribing guidelines and they ruled against hanging of such signs in triage. They were concerned that these signs might be a deterrent to patients seeking emergency medical care. Information such as brochures or signage can be handed out or can be made visible only after the medical screening exam has been completed. (B) For more information, see EMTALA Section of Toolkit.

Joint Commission The Joint Commission mandates a pain assessment and then either treatment or referral for treatment. Treatment does not necessitate opioids. The Joint Commission has no mandate that requires ED physicians to provide pain medication in the ED / Urgent Care Center or write for pain medication upon discharge. (A)

Patient Satisfaction Safe Pain Medication Prescribing guidelines have already been implemented in Emergency Department and Urgent Care Centers across the country including in Washington and Ohio states and most recently San Diego County and Kaiser-Permanente Southern California facilities. San Diego and Imperial Counties implemented the use of the patient handout in March 2013; Kaiser's EDs and Urgent Care Centers began using the handouts in January 2014.

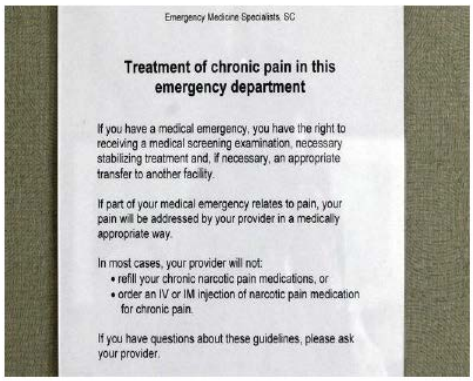
The effect and impact of the implementation of these safe opioid prescribing guidelines and practices on patient satisfaction is always a concern that is raised. There is published and emerging reports from the field that while there may be a few initial patient complaints, patient satisfaction measured on surveys is not affected and actually has improved.

- San Diego and Imperial Counties implemented the use of the patient handout in March 2013; patient satisfaction scores were unaffected by the implementation of the guidelines in the EDs. In San Diego, no hospital reported a change in patient satisfaction score based on the Safe Prescribing guidelines.

- Lack of Association Between Press Ganey Emergency Department Patient Satisfaction Scores and Emergency Department Administration of Analgesic Medications, Annals of Emergency Medicine, Vol. 64, Issue 5, November 2014, pages 469-481

New Evidence: Patient Satisfaction Scores in the ED Not Causally Linked to Giving Opioids

- Study conducted in ER setting at Umass Medical School.
- 4749 patients seen in ED setting 2009-2011
  - 48.5% received analgesics
  - 29.6% received opioid analgesics
- **Conclusion:**
  - Persons receiving opioid and non-opioid analgesics had lower overall satisfaction scores.
  - Patients with chronic pain had lower scores, irrespective of treatment.
  - Analgesic medications, opioid analgesics, and high morphine equivalent treatments were associated with lower overall scores.
  - Opioids not associated with better scores.
  - High dose opioids inconsistently associated with lower scores.


Emergency Medicine Specialists, SC

Treatment of chronic pain in this emergency department

If you have a medical emergency, you have the right to receiving a medical screening examination, necessary stabilizing treatment and, if necessary, an appropriate transfer to another facility.

If part of your medical emergency relates to pain, your pain will be addressed by your provider in a medically appropriate way.

In most cases, your provider will not:
- refill your chronic narcotic pain medications, or
- order an IV or IM injection of narcotic pain medication for chronic pain.

If you have questions about these guidelines, please ask your provider.

Source: Tayler M. Schwartz, Miao Tai, Kavita M. Babu, Roland C. Merchant Lack of Association Between Press Ganey Emergency Department Patient Satisfaction Scores and Emergency Department Administration of Analgesic Medications
Annals of Emergency Medicine, Volume 64, Issue 5, November 2014, Pages 469-481

- The Southern California Kaiser Permanente Emergency Departments, consisting of 14 sites caring for close to 1,000,000 patients in 2015, adopted the Safe Opioid Prescribing Guidelines Jan 1st 2014. While there was concern among SCPMG physicians that these recommendations might lower customer satisfaction scores, this has not been borne out by the data. Internal randomized satisfaction surveys (MAPPS) show that in 2014 the regional average for patient Emergency Physician satisfaction actually increased slightly, while in 2015 it stayed largely flat. So far 2016 data shows another slight increase in our patient satisfaction scores.

  In summary, these safe opioid prescribing guidelines are not only safer for our patients, but concerns about a detrimental effect on patient satisfaction have proven to be unfounded.

  Todd Newton, MD
  SCAL KP Regional Chief, Emergency Medicine
  March, 2016

References:

(A) ACEP April 1, 2013 Robert Bitterman M.D., member ACEP Medical Legal Committee, Is *"Severe Pain" considered an Emergency Medical Condition under EMTALA?*
(B) ACEP eNow January 22, 2014 Kevin Klauer DO, EJD, FACEP, Medical Editor in Chief and Richard Wild MD, JD, MBA, FACEP, CMS Chief Medical Officer for the Atlanta Regional Office (Region 4) ED Waiting Room Posters on Prescribing Pain Medications May Violate EMTALA

EMTALA

This section of the toolkit provides aid to Emergency Department and Urgent Care Centers Medical Directors in their adoption of the L.A. County Safe Pain Medicine Prescribing.

- EMTALA and the Joint Commission for Emergency Departments
- EMTALA and Urgent Care Centers

Safe Pain Medicine Prescribing in Emergency Departments:

EMTALA and the Joint Commission

This document is to aid Emergency Department Medical Directors in their adoption of the *L.A. County Safe Pain Medicine Prescribing in Emergency Departments* patient handout and how it reconciles with EMTALA and the Joint Commission.

EMTALA and Pain

Many misconceptions exist regarding EMTALA and the evaluation and treatment of patients with pain as a complaint. EMTALA regulations state that any patient who presents to a Medicare receiving hospital with a complaint of pain, including severe pain, must be provided an appropriate medical screening examination (MSE) to determine if an emergency medical condition exists. The MSE may include any resources available in your hospital to determine if an Emergency Medical Condition exists, including laboratory testing and imaging.

The requirement for an MSE includes patients with chronic pain conditions who present to the Emergency Department with a complaint of pain. The MSE will determine if the complaint of pain is a result of an emergency medical condition. An emergency medical condition is defined as a medical condition such that the absence of immediate medical treatment could result in (1) placing the individual's (or unborn child's) health in serious jeopardy, (2) serious impairment of bodily function, or (3) serious dysfunction of any organ or part. Pain alone is not considered by the EMTALA regulations to be an emergency medical condition. (A, E) In a recent review on the topic, Dr. Robert Bitterman MD, JD, FACEP, a nationally recognized physician-attorney expert specializing in EMTALA compliance issues, uses the example of a patient with chronic low back pain complaining of severe pain. He explains that the patient does not have an emergency medical condition unless that pain is related to, for example, an aortic aneurysm rupture or a herniated disc causing neurological dysfunction where immediate treatment is necessary to avoid the imminent danger of death or serious disability. (A) Once an emergency medical condition is determined to not exist, the Medical Screening Examination is complete.

EMTALA also does not regulate nor mandate the actual treatment of pain. EMTALA only mandates the evaluation of pain as a possible symptom of an emergency medical condition. (A)

Joint Commission and Pain

The Joint Commission does have its own regulations regarding the evaluation and treatment of pain. The Joint Commission mandates a pain assessment and then either treatment of the patient's pain or referral of the patient for treatment. The Joint Commission does not mandate that a patient's pain be treated with opiate medications. (B) In Dr. Bitterman's back pain example, the ED physician may, after the MSE, decide the best treatment options include bed rest, heat packs, and referral back to the patient's primary care provider. The Joint Commission has no regulations requiring ED physicians to provide pain medications in the ED or write pain prescriptions upon discharge. (A)

EMTALA and Signage referring to Safe Prescribing Guidelines

Hospitals and State Departments of Health all across the country are developing guidelines for prescribing opioid medications in the Emergency Department for chronic pain patients. These guidelines have included patient brochures to be handed out and posters explaining the guidelines that have been hung in the waiting rooms or treatment rooms of the Emergency Departments. The intention of the posters, by well-meaning Emergency Departments, was to inform patients regarding the ED's controlled prescription policy.

Recently the CMS Atlanta Regional Office in South Carolina (Region 4) stated an opinion regarding the use of "pain posters" in EDs. Although the CMS National Office in Baltimore has not specifically addressed this issue, other CMS Regional Offices have also concurred with the recent Atlanta Regional Office's rulings. The Region 4 opinion was also based on consultation with the CMS National Office directly. Because of the interest, it is expected that the CMS National Office may issue a national memorandum on the topic of prescription opioid signage. (C) CMS' opinion is based on EMTALA compliance. The following bullet points are a summary of the CMS Atlanta Office's rulings (D):

• Signage indicating a patient's right to a Medical Screening Examination must be prominently displayed.
• Signage that refers to "Prescribing Pain Medication in the Emergency Department" or any similar language, which the hospital might choose to post in patient waiting rooms or treatment rooms, **might be considered to be coercive or intimidating to patients who present to the ED with painful medical conditions,** thereby **violating both the language and the intent of the EMTALA statute and regulations**." (D)
• CMS is concerned that "pain posters" in the ED may discourage a patient from staying for a medical screening exam or discourage a patient from seeking care in the future.
• CMS is also concerned that a "pain poster" would also raise the question of whether or not a hospital would provide stabilizing treatment for an emergency medical condition when opioids may be appropriate.
• Hospitals that use such signage, or any signage that may have the real or perceived effect of discouraging an individual from seeking care, are at risk for being found EMTALA non-compliant.
• CMS does not appear to have an issue with the actual development of opiate prescription guidelines nor the education of patients as long as any education is done after the Medical Screening Exam has been completed.
• "It is within the bounds of reasonable professional judgment and discretion for a physician or other licensed healthcare practitioner to provide or withhold opioids and/or other methods of pain control, depending on the specific clinical circumstances of an individual's presentation". (D)
• "It is left to the judgment of the provider as to how best to give specific patient-centered education, including handouts, policies, and institutional protocols. But again, it is emphasized that patient education should take place after a patient focused medical screening exam is completed and not by posting general policies and procedures or displaying such materials in the waiting area." (D)

Summary
All patients who present to the ED should have a medical screening examination to determine if an emergency medical condition exists. Any information regarding an ED's policy about controlled substances, whether as brochures or posters, should only be given to or seen by the patient after the medical screening examination has been completed.

A. ACEP April 1, 2013 Robert Bitterman M.D., member ACEP Medical Legal Committee, *Is "Severe Pain" considered an Emergency Medical Condition under EMTALA?*
B. Joint Commission Standard PC.01.02.07: The hospital assesses and manages the patient's pain.
C. Ohio Hospital Association Statement *Emergency Department Opiate Prescribing Guidelines* January 15, 2014
D. ACEP eNow January 22, 2014 Kevin Klauer DO, EJD, FACEP, Medical Editor in Chief and Richard Wild MD, JD, MBA, FACEP, CMS Chief Medical Officer for the Atlanta Regional Office (Region 4) *ED Waiting Room Posters on Prescribing Pain Medications May Violate EMTALA*
E. AAEM Clinical Practice Statement *Emergency Department Opioid Prescribing Guidelines for the Treatment of Non-Cancer Related Pain* 11/12/2013

Safe Pain Medicine Prescribing in Urgent Care Centers:

EMTALA

This document is to aid Urgent Care Center Medical Directors in their adoption of the *L.A. County Safe Pain Medicine Prescribing in Urgent Care Centers* patient handout and how it reconciles with EMTALA.

EMTALA and Urgent Care Centers

EMTALA applies to all Medicare participating hospitals with an emergency department and applies to anyone coming to the hospital or its campus seeking emergency medical services. Under EMTALA, the hospital must provide a medical screening examination to determine whether an emergency medical condition exists and then must treat or stabilize the patient so he or she may be transferred.

It is important for every Urgent Care Center to understand how the EMTALA regulations may or may not apply to that facility. If an Urgent Care Center is a department of a hospital on the hospital campus, then the center must comply with EMTALA obligations. If the Urgent Care Center is off campus but is owned or partially owned by the hospital, then the center must comply with EMTALA obligations. If the Urgent Care Center is freestanding and independent and is not owned or partially owned by a hospital, then EMTALA does not apply.

For those Urgent Care Centers that are hospital-owned and therefore fall under EMTALA regulations, we encourage you to go to the Safe Med LA website and refer to the EMTALA and Joint Commission guidelines as it pertains to Safe Prescribing in Emergency Departments; this can be found on the webpage of the Safe Prescribing Medical Practice Action Team. In brief, the Center for Medicare and Medicaid Services (CMS) has stated that, although they agree with safe pain prescribing guidelines for emergency departments, the guidelines cannot be seen as a deterrent for a patient to seek emergency care and therefore should not be given to the patient in a form of a handout or posted in the waiting room until after the medical screening examination has been completed.

For those Urgent Care Centers that are freestanding, independent, and not hospital-owned, EMTALA obligations do not apply and therefore the Urgent Care Centers will be under fewer restrictions in regards to patient education as it pertains to safe pain prescribing. Unlike Emergency Departments, freestanding, independent Urgent Care Centers can begin patient education in regards to safe pain prescribing in the waiting room upon the patients' arrival. Urgent Care Centers who have adopted the safe prescribing guidelines have hung posters in their waiting room or made the safe prescribing handout readily available in the waiting room.

1. ACEP April 1, 2013 Robert Bitterman M.D., member ACEP Medical Legal Committee, *Is "Severe Pain" considered an Emergency Medical Condition under EMTALA?*
2. Joint Commission Standard PC.01.02.07: The hospital assesses and manages the patient's pain.
3. Ohio Hospital Association Statement *Emergency Department Opiate Prescribing Guidelines* January 15, 2014
4. ACEP eNow January 22, 2014 Kevin Klauer DO, EJD, FACEP, Medical Editor in Chief and Richard Wild MD, JD, MBA, FACEP, CMS Chief Medical Officer for the Atlanta Regional Office (Region 4) *ED Waiting Room Posters on Prescribing Pain Medications May Violate EMTALA.*
5. AAEM Clinical Practice Statement *Emergency Department Opioid Prescribing Guidelines for the Treatment of Non-Cancer Related Pain* 11/12/2013.
6. Urgent Care News M Burnstein, R Harris and L Love. Top Four Legal Issues to Consider When Opening an Urgent Care Center. Sept 2015.
7. KH Looney, MK O'Brien, J Sundock Urgent Care Centers and Free Standing Emergency Rooms: A Necessary Alternative Under the ACA American Health Lawyers Association.

Chronic Pain Screening and Monitoring Tools

This section of the toolkit provides a list of Risk Assessment Tools and Ongoing Assessment and monitoring tools.

Chronic Pain Screening and Monitoring Tools

Chronic Pain Screening and Monitoring Tools

Below are lists of Risk Assessment Tools and Ongoing Assessment and Monitoring Tools from www.opioidrisk.com. Most are paper-based, and some are duplicative with the resources referenced above.

Risk Assessment Tools: ORT, DIRE, SOAPP, SOAPP-R, and SISAP
ORT: Opioid Risk Tool http://www.opioidrisk.com/node/884 ORT assesses risk of aberrant behaviors when patients are prescribed opioids for chronic pain; administered by self report; intended for primary care use; high degree of sensitivity and specificity for determining which individuals are at risk for opioid abuse; preferable to SOAPP in low-risk populations; 5 items, less than 1 minute to administer and score; copyrighted.
DIRE: Diagnosis, Intractability, Risk, Efficacy http://www.opioidrisk.com/node/942 DIRE assesses risk of opioid abuse and suitability of candidates for long-term opioid therapy; administered by patient interview; specifically designed for primary care use; 7 items, less than 2 minutes to administer and score; unclear copyright status.
SOAPP: Screener and Opioid Assessment for Patients with Pain http://www.opioidrisk.com/node/940 SOAPP assesses patients at high risk for opioid abuse prior to treatment; administered by self report; intended for primary care use; preferable to ORT in high-risk populations; available in three formats: 5, 14 and 24 items, 5-10 minutes to administer and score; copyrighted.
SOAPP-R: Screener and Opioid Assessment for Patients in Pain - Revised http://www.opioidrisk.com/node/941 SOAPP-R assesses risk of opioid abuse in chronic pain patients; administered by self report; intended for primary care use; may be an improvement over the original version (SOAPP) in screening risk potential for deviant medication-related behavior among chronic pain patients; 14 items; 5 minutes to administer and score; copyrighted.
SISAP: Screening Instrument for Substance Abuse Potential http://www.opioidrisk.com/node/895 SISAP assesses patients at risk for opioid abuse, particularly those individuals with a history of substance abuse and aids in proper pain management by focusing on appropriate use of opioid therapy for both high risk and low risk patients; administered by patient interview; intended for primary care use; 5 items, less than 1 minute to administer and score; no copyright.
Ongoing Assessment and Monitoring Tools: COMM, ABC, PMQ, and PDUQ
COMM: Current Opioid Misuse Measure http://www.opioidrisk.com/node/946 COMM assesses aberrant medication-related behaviors of chronic pain patients; administered by self report; intended for primary care use; 17 items, less than 10 minutes to administer and score; copyrighted.
ABC: Addiction Behaviors Checklist http://www.opioidrisk.com/node/947 ABC assesses characteristic addictive behaviors in chronic pain patients prescribed opioid medications; administered by patient interview; intended for primary care use; 20 items, about 10 minutes to administer and score; copyrighted.
PMQ: Pain Medication Questionnaire http://www.opioidrisk.com/node/943 PMQ assesses characteristic addictive behaviors in chronic pain patients prescribed opioid medications; administered by self report; intended for primary care use; 26 items, about 10 minutes to administer and score; copyrighted.
PDUQp: Prescription Drug Use Questionnaire Self-Report http://www.opioidrisk.com/node/945 PDUQp assesses problematic opioid medication use in chronic pain patients; administered by self report; intended for primary care use and to be used when abuse of pain medication is suspected; 42 yes/no items, about 20 minutes to administer and score; unclear copyright status.

Resources for Pain Management and Substance Use Disorder Management and Treatment

This section of the tool kit provides information on resources available to help clinicians obtain clinical advice and/or arrange referral/consultation for patients with pain management and/or substance use disorders.

- UCSF Substance Use Warm Line:

Substance Use Warm Line
Peer-to-Peer Consultation and Decision Support
7 am – 3 pm PST Monday – Friday
855-300-3595

- Substance Use Treatment Centers in LA County

CLINICIAN CONSULTATION CENTER
National rapid response for HIV management and bloodborne pathogen exposures.

Substance Use Warmline

Peer-to-Peer Consultation and Decision Support

7 am – 3 pm PST Monday - Friday

855-300-3595

Free and confidential consultation for clinicians from the Clinician Consultation Center at San Francisco General Hospital focusing on substance use in primary care

Objectives of the Substance Use Warmline:

- Support primary care providers in managing complex patients with addiction, chronic pain, and behavioral health issues
- Improve the safety of medication regimens to decrease the risk of overdose
- Enhance the treatment, care and support for people living with or at risk for HIV
- Discuss useful strategies for clinicians in managing their patients living with substance use, addiction and chronic pain.

Consultation topics include:

- Assessment and treatment of opioid, alcohol, and other substance use disorders
- Approaches to suspected misuse, abuse, or diversion of prescribed opioids
- Methods to simplify opioid-based pain regimens to reduce risk of misuse and toxicity
- Urine toxicology testing- when to use it and what it means
- Use of buprenorphine and the role of methadone maintenance
- Withdrawal management for opioids, alcohol, and other CNS depressants
- Harm reduction strategies and overdose prevention
- Managing substance use in special populations (pregnancy, HIV, hepatitis)
- Productive ways of discussing (known or suspected) addiction with patients.

The CCC's multi-disciplinary team of expert physicians, clinical pharmacists and nurses provides consultation to help clinicians manage complex patient needs, medication safety, and a rapidly evolving regulatory environment.

Learn more at http://nccc.ucsf.edu/clinical-resources/substance-use-resources/

This project is supported by the Bureau of Primary Health Care (BPHC) and the HIV/AIDS Bureau (HAB) AIDS Education and Training Centers (AETCs) of the Health Resources and Services Administration (HRSA) in the U.S. Department of Health & Human Services (DHHS)

Safe Pain Medicine Prescribing

Referrals for Substance Use Disorder Treatment

How to assess/screen for substance use disorder?

Use the four CAGE Questions as a screening test for Alcohol Dependence (Note: two "yes" responses indicate that the possibility of alcoholism should be investigated further).

- Have you ever felt you needed to **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt **G**uilty about drinking?
- Have you ever felt you needed a drink first thing in the morning (**E**ye-opener) to steady your nerves or get rid of a hangover?

Where should I refer the patient?

- Contact your clinic Social Worker for assistance.
- Find out if the patient has health insurance: refer to the patient's health plan.
- Medi-Cal patients can be referred for substance use disorder services by calling **888-742-7900**. Additional information is available on the website of the Substance Abuse Prevention and Control (http://publichealth.lacounty.gov/sapc/).
- Instruct the patient to call **2-1-1** or go to http://www.211la.org/ and ask for information on treatment services for drug use disorders.
  - 211 LA County is a private, nonprofit 501(c) (3) organization, formerly known as INFO LINE of Los Angeles. It provides free, confidential services 24 hours a day, 7 days a week in English, Spanish and more than 140 other languages via a tele-interpreting service. Services are also provided for individuals with hearing impairments. It functions as a gateway to the county's vast and complex social service delivery system.

Is there any advice available for Physicians?

- For Advice, you may call the UCSF Substance Abuse Warm Line for Peer-to-Peer Consultation & Decision Support.
  - 7 am – 3 pm PST, Monday –Friday
  - **855-300-3595**
  - Free and Confidential consultation for clinicians from the Clinician Consultation Center at San Francisco General Hospital focusing on substance use in primary care.

County of Los Angeles Community Assessment Services Centers are available for referral. See the listing of these Centers by Geographic Area (SPA).

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
COMMUNITY PROGRAM SERVICES DIVISION
ASSESSMENTS REFERRALS BY *ZIP CODE*

SPA	COMMUNITY ASSESSMENT SERVICES CENTER (CASC)	ASSESSMENT TYPES	**ZIP CODES	CASC DIRECTOR
1	Tarzana Treatment Center **Lancaster CASC– (Lead)** 44447 N. 10th Street West Lancaster, CA 93534 Appointment : (661) 726-2630 x 4100 Arisah Muhammad x4311 amuhammad @tarzanatc.org	Assessing – CW, DCFS, GP, GR, PC-1210, AB 109	93243, 93523, 93532, 93534, 93535, 93536, 93539, 93584, 93586	Alesia Ping-Diflore Phone: (661) 726-2630 x 4220 Fax: (661) 952-1172
1	San Fernando Valley Community MH Center **Palmdale CASC** 1050 E. Palmdale Blvd #209 Palmdale, CA 93550 Appointment: (661) 266-4517 Additional assistance: Ben Medina bmedina@sfvcmhc.org	Assessing – CW, DCFS, GP, GR, AB 109	93510, 93543, 93544, 93550, 93551, 93552, 93553, 93560, 93563, 93590, 93591	Serina Rosenkjar, Ph.D. Phone: (661) 266-4517 Fax : (661) 266-9176 srosenkjar@sfvcmhc.org
2	San Fernando Valley Community MH Center **Van Nuys CASC - (Lead)** 14515 Hamlin St. Van Nuys, CA 91411 Appointment: (818) 285-1900 Additional assistance: Ben Medina bmedina@sfvcmhc.org	Assessing – CW, DCFS, GP, GR, AB 109	San Fernando Valley 91040, 91042, 91046, 91331, 91340, 91341, 91342, 91350, 91351, 91352, 91401, 91402, 91404, 91405, 91423, 91521, 91601, 91602, 91603, 91604, 91605, 91606, 91607, 91608, Santa Clarita Valley 91321, 91350, 91351, 91387, 91390	Serina Rosenkjar, Ph.D. Phone: (818) 285-1900 Fax: (818) 285-1906 srosenkjar@sfvcmhc.org
2	Tarzana Treatment Center **Tarzana CASC** 18646 Oxnard Street Tarzana, CA 91356 Appointment: (818) 654-3853 Additional assistance Lucia Leon x 2062 lleon@tarzanatc.org	Assessing – CW, DCFS, GP, GR, PC-1210, AB-109	San Fernando Valley 90290, 91301, 91302, 91303, 91304, 91306, 91307, 91311, 91316, 91321, 91324, 91325, 91326, 91330, 91335, 91343, 91344, 91345, 91352, 91354, 91355, 91356, 91361, 91362, 91364, 91365, 91367, 91381, 91382, 91384, 91403, 91406, 91411, 91436, Santa Clarita Valley 91354, 91355, 91381, 91382, 91384	Stan Galperson Phone: (818) 996-1051 x 3811 Fax : (818) 996-1753 Sgalperson@tarzanatc.org

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SPA	COMMUNITY ASSESSMENT SERVICES CENTER (CASC)	ASSESSMENT TYPES	**ZIP CODES	CASC DIRECTOR
3	Prototypes **El Monte CASC (LEAD)** 11100 East Valley Blvd., Suite 116 El Monte, CA 91731 Appointment: (626) 444-0705 Additional assistance Alicia Trivison - Madrigal atrivison-madrigal @prototypes.org	Assessing – CW, DCFS, GP, GR, and PC-1210, AB-109	91006, 91007, 91010, 91016, 91702, 91706, 91722, 91723, 91724, 91731, 91732, 91733, 91734, 91739, 91744, 91745, 91746, 91747, 91748, 91770, 91775, 91776, 91780, 91790, 91791, 91792, 92621	Alicia Trivison-Madrigal Phone: (626) 444-0705 Fax: (626) 444-0710 Atrivison-madrigal@prototypes.org
	Prototypes **Pomona CASC** 831 East Arrow Highway Pomona, CA 91767 Appointment: (909) 398-4383 Additional assistance: Stephanie Armbruster sarmbruster@prototypes.org	Assessing – CW, DCFS, GP, GR, PC-1210, AB-109	91711, 91740, 91741, 91750, 91765, 91766, 91767, 91768, 91769, 91773, 91789	Alicia Trivison-Madrigal Phone: (626) 444-0705 Fax: (626) 444-0710 Atrivison-madrigal@prototypes.org
	Prototypes **Pasadena CASC** 2555 E. Colorado Blvd., Suite 308 Pasadena, CA 91101 Appointment: (626) 449-2433 Additional assistance: Stephanie Armbruster sarmbruster@prototypes.org	Assessing – CW, DCFS, GP, GR, PC-1210, AB-109	91001, 91011, 91020, 91023, 91024, 91030, 91101, 91102, 91103, 91104, 91105, 91106, 91107, 91108, 91201, 91202, 91203, 91204, 91205, 91206, 91207, 91208, 91214, 91501, 91502, 91504, 91505, 91506, 91754, 91755, 91801, 91802, 91803	Alicia Trivison-Madrigal Phone (626) 444-0705 Fax (626) 444-0710 Atrivison-madrigal@prototypes.org

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SPA	COMMUNITY ASSESSMENT SERVICES CENTER (CASC)	ASSESSMENT TYPES	**ZIP CODES	CASC DIRECTOR
4	Homeless Health Care **Los Angeles CASC (LEAD)** 2330 Beverly Blvd. Los Angeles, CA 90057 Appointment: (213) 342-3114 Additional assistance: David Murillo X141 dmurillo@hhcla.org	Assessing – CW, DCFS, GP, GR, PC-1210, AB-109		Delia Mojarro Phone: (213) 342-3114 x137 Fax: (213) 342-3124 dmojarro@hhcla.org
	BHS Hollywood 6838 W. Sunset Blvd. Hollywood, CA 90028 Appointment: (323) 461-3161 Additional assistance: Jovita Hernandez jhernandez@bhs-inc.org	Assessing – CW, GP, GR	90004, 90005, 90006, 90007, 90008, 90010, 90012, 90013, 90014, 90015, 90017, 90019, 90020, 90021, 90023, 90026,90027, 90028, 90029, 90031, 90032, 90033, 90036, 90038, 90039, 90041, 90042, 90046, 90048, 90057, 90065,90068, 90069, 90071	BHS Sites in SPA 4 Lisa Sandoval Phone: (310) 973-2272 x1289 FAX: (310) 973-7813 lsandoval@bhs-inc.org
	BHS East Los Angeles 3421 East Olympic Blvd. Los Angeles, CA 90023 Appointment: (323) 262-1786 Additional assistance: John Romero jromero@bhs-inc.org	Assessing – CW, GP, GR		
5	Didi Hirsch Community MH Center **Culver City CASC (LEAD)** 11133 Washington Blvd. Culver City, CA 90230 Appointment: (310) 895-2339 Additional assistance: Charles Bullitts cbullitts@didihirsch.org	Assessing – CW, DCFS, GP, GR, PC-1210, AB-109	90024, 90025, 90034, 90035, 90045, 90049, 90056, 90064, 90066, 90067, 90077, 90094, 90210, 90211, 90212, 90230, 90232, 90265, 90272, 90291, 90292, 90293, 90401, 90402, 90403, 90404, 90405	RuthAnn Markusen Phone: (310) 895-2339 Fax: (310) 895-2353 rmarkusen@didihirsch.org

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SPA	COMMUNITY ASSESSMENT SERVICES CENTER (CASC)	ASSESSMENT TYPES	**ZIP CODES	CASC DIRECTOR
6	SSG-Integrated Care System **South Los Angeles CASC (LEAD)** 5715 S. Broadway Avenue Los Angeles, CA 90044 Phone: (213) 895-7700 FAX: (323) 778-2599 Additional assistance: Ruby Medina rmedina@hopics.org	Assessing – CW, DCFS, GP, GR, PC-1210, AB-109	90002, 90003, 90011, 90016, 90018, 90037, 90043, 90044, 90058, 90062, 90301, 90302, 90303, 90304, 90305.	Bambi Piland, Phone: (323) 948-0444 Fax; (323) 948-0443 bpiland@hopics.org
	SSG-Shields for Families 11601 S. Western Avenue Los Angeles, CA 90047 Appointment: (323) 242-5000 x1253 Additional assistance: Sara Tienda x 1276 stienda@ shieldsforfamilies.org	Assessing – CW, GP, GR	90001, 90044, 90047, 90059, 90061, 90220, 90221, 90222, 90262, 90723.	Shields for Families sites Georgea Madeira Phone: (323) 242-5000 x1257 Fax: (323) 242-3521 gmadeira@ shieldsfor families.org
	SSG-Shields for Families 11705 Deputy Yamamoto Place Lynwood, California 90262 Appointment: (323) 242-5000 Additional assistance: Sheila Smith-Cook ssmith-cook@shieldsforfamilies.org	Assessing – AB 109		Delonda Groenow Phone: (323) 242-5000 x1253 Fax: (323) 242-5011 dgroenow@shieldsforfamilies.org
7	California Hispanic Commission **Pico Rivera CASC (LEAD)** 9033 Washington Blvd. Pico Rivera, CA 90660 Appointments (562) 942-9625 Additional assistance: Natasha Medina nmedina@chcada.org	Assessing – CW, DCFS, GP, GR, PC-1210, AB-109	90022, 90023, 90040, 90063, 90201, 90240, 90241, 90242, 90255, 90270, 90280, 90601, 90602, 90603, 90604, 90605, 90606, 90631, 90638, 90640, 90650, 90660, 90670, 90701, 90703, 90706, 90712, 90713, 90715, 90716	Sam Campbell Phone: (562) 942-9625 Fax: (562) 942-9695 scampbell@chcada.org
7A	California Hispanic Commission 5801 E. Beverly Blvd. Los Angeles, CA 90022 Appointments: (323) 728-7707 Additional assistance: Natasha Medina nmedina@chcada.org	Assessing – GP Metro East DPSS – GR	90022, 90023, 90040, 90063, 90201, 90240, 90241, 90242, 90255, 90270, 90280, 90601, 90602, 90603, 90604, 90605, 90606, 90631, 90638, 90640, 90650, 90660, 90670, 90701, 90703, 90706, 90712, 90713, 90715, 90716	Sam Campbell Phone: (562) 942-9625 Fax: (562) 942-9695 scampbell@chcada.org

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SPA	COMMUNITY ASSESSMENT SERVICES CENTER (CASC)	ASSESSMENT TYPES	**ZIP CODES	CASC DIRECTOR
8	Behavioral Health Services **Gardena CASC (LEAD)** 15519 Crenshaw Blvd. Gardena, CA 90249 Appointments : (310) 973-2272 Additional assistance: Edward Rivera erivera@bhs-inc.org	Assessing – CW, DCFS, GP, GR, PC-1210, AB-109	90245, 90247, 90248, 90249, 90250, 90254, 90260, 90266, 90274, 90277, 90278, 90501, 90502, 90503, 90504, 90505, 90506, 90717, 90745, 90746, 90747	Lisa Sandoval Phone: (310) 973-2272 x1289 FAX: (310) 973-7813 lsandoval@bhs-inc.org
	Behavioral Health Services 1318 North Avalon Boulevard, Suite A, Wilmington, CA 90744 Phone: (310) 549-2710 FAX: (310) 549-2715	Assessing – CW, DCFS, GP,	90744, 90748	Lisa Sandoval Phone: (310) 973-2272 x 1289 FAX: (310) 973-7813 lsandoval@bhs-inc.org
	Behavioral Health Services **Long Beach CASC** 1775 Chestnut Avenue Long Beach, CA 90813 Appointments Phone: (562) 218-8387 FAX: (562) 218-7069 Additional assistance: Mary Armenta maguilar@bhs-inc.org	Assessing – CW, DCFS, GP, GR, PC-1210, AB-109	90704, 90710, 90731, 90732, 90802, 90803, 90804, 90805, 90806, 90807, 90808, 90810, 90813, 90814, 90815, 90822, 90840	Lisa Sandoval Phone: (310) 973-2272 x 1289 FAX: (310) 973-7813 lsandoval@bhs-inc.org

AB 109 – Public Safety Realignment
CW – CalWORKs
DCFS – Department of Children and Family Services
GP – General population
GR – General Relief
PC – 1210- Substance Abuse Crime Prevention Act of 2000
SPA – Service Planning Area

**This Zip Code list has been developed to assist the user in determining the closest assessment site. For the convenience of the participant please provide the participant with a choice of locations.

TOLL FREE - HELP LINE 1-800 564-6600
http://publichealth.lacounty.gov

Other Resources

This section of the toolkit provides other resources for safe prescribing.

Safe Pain Medication Prescribing in Emergency Departments and Urgent Care Centers:

Other Resources

CURES – CA Prescription Drug Monitoring Program (registration required as of 7/1/2016)

See https://oag.ca.gov/cures
Training documents and videos available via https://oag.ca.gov/cures/publications

Primary Care - Community Clinics and Health Centers

Refer from ED or Known PCP or original prescriber of opioid
Through Health Plan for triage and follow-up
Community Clinics and Health Centers available for triage, referral, and follow-up:

- http://gis.oshpd.ca.gov/atlas/places/list-of-clinics/county/los%20angeles
- http://dhs.lacounty.gov/wps/portal/dhs/locations/

AAEM Guidelines

Cheng, D., Majledi, N, Heller, M., Rosenbaum S., Winters, M. (2013); Emergency Department Opioid Prescribing Guidelines for the Treatment of Non-Cancer Related Pain. American Academy of Emergency Medicine. http://www.aaem.org/UserFiles/file/Emergency-Department-Opoid-Prescribing-Guidelines.pdf
Retrieved from www.aaem.org/em-resources/clinical-practice-statements - accessed April 15, 2016.

ACEP Guidelines

Cantrill, S. V., Brown, M. D., Carlisle, R. J., Delaney, K. A., Hays, D. P., Nelson, L. S., ... & Whitson, R. R. (2012). Clinical policy: critical issues in the prescribing of opioids for adult patients in the emergency department. Annals of emergency medicine, 60(4).
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Retrieved from http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm - accessed April 15, 2016.

Washington State Guidelines

Interagency Guideline on Prescribing Opioids for Pain. 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.
http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf
Retrieved via www.agencymeddirectors.wa.gov - accessed April 15, 2016.

Oregon State Guidelines

Oregon Pain Guidance. (2014) Opioid Prescribing Guidelines: A Provider and Community Resource.
http://www.southernoregonopioidmanagement.org/app/content/uploads/2014/04/OPG_Guidelines.pdf
Retrieved via http://www.oregonpainguidance.com/opioid-prescribing-guidelines-2/introduction - accessed April 15, 2016.

Medical Board of CA Guidelines

Medical Board of California. (2014) Guidelines for Prescribing Controlled Substances for Pain.
http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf. Retrieved from
http://www.mbc.ca.gov/licensees/prescribing - accessed April 17, 2016

Online Continuing Medical Education (CME) on Pain Management

- Boston University School of Medicine -- SCOPE of Pain: Safe and Competent Opioid Prescribing Education. Offered in collaboration with the Council of Medical Specialty Societies (CMSS) and the Federation of State Medical Boards (FSMB), this program addresses the FDA mandate to manufacturers of extended release/long-acting (ER/LA) opioid analgesics, by providing comprehensive prescriber education in the safe use of these medications.
  http://www.scopeofpain.com/

- American Society of Addiction Medicine - ER/LA Opioid REMS: Achieving Safe Use While Improving Patient Care http://www.softconference.com/asam/slist.asp?C=5383

- American College of Physicians - Safe Opioid Prescribing
  http://www.pri-med.com/PMO/Featured/Pain%20Management/Default.aspx

- AAFP training resource (1 hour) aafp.org/webcast/chronic-pain

- AAFP (4 hour with Completer status for this ER/LA Opioid REMS, and includes webcast, CME bulletin, and interactive components)
  aafp.org/rems-online
  http://www.drugabuse.gov/opioid-pain-management-cmesces

- In the near future, the California Medical Board will be offering a 3-hour, web-based CME specific to chronic pain management.

- Collaborative Opioid Prescribing Education (COPE) Online Training for Chronic Pain (up to 4 hours of CME)
  http://www.coperems.org/

Visit our website at: http://www.SafeMedLA.org

Hospital Association of Southern California: Task Force in Los Angeles Addresses Safe Pain Medication Prescribing in Emergency Departments

Appendix: Background Information, Data, and Goals

This section of the toolkit provides background information, data, and goals.

Safe Prescribing Medical Practice Action Team (MPAT)
Background Information, Data, and Goals

Activate the medical community to support evidence-based non-cancer pain management and safe opioid prescribing to reduce opioid over-prescribing, misuse, abuse, and diversion.

- **Expand to Urgent Care Centers the adoption and implementation of the AAEM guidelines and patient information communications**

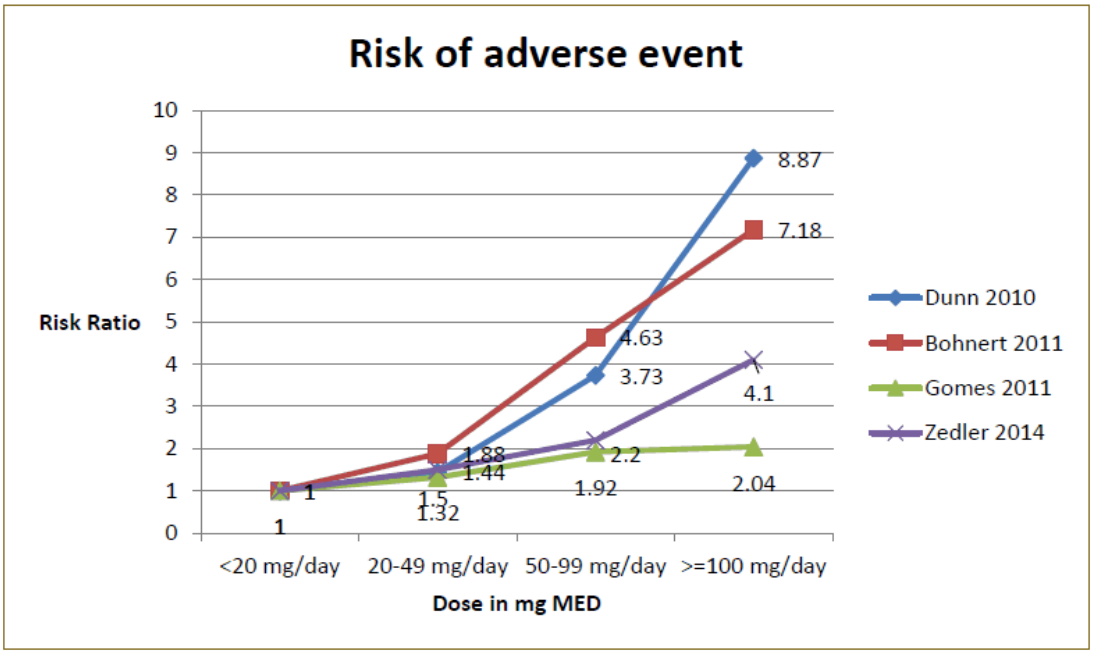
CALL TO ACTION:

BE PART OF THE SOLUTION AND NOT PART OF THE PROBLEM OF PRESCRIPTION OPIOID OVER-PRESCRIBING

- **46 people die each day in the US from prescription opioids**
- **Sales/prescribing of opioids in the US has increased 400% from 2000-2010. This is unlikely due to a fourfold increase in severe pain.**
- **Overdose and Death related to Prescription opioids has increased 200% since 2000**
- **More people die each year from prescription opioids than from motor vehicle accidents or from heroin and cocaine combined**
- **LA County (2006-2013):**
  - **Prescribing of opioids increased 22%** (2008 to 2012)
  - **ED visits related to opioids increased 171%**
  - **Hospitalizations related to opioids increased 30%**
  - **Substance use disorder treatment admissions for opioid increased 81%**
  - **Deaths from opioids is averaging almost 400 people per year**
- **Who's prescribing opioid medications?**
  - **24.5% of LA County prescribers wrote 91% of opioid prescriptions in 2012**
  - **2.5% of LA County prescribers wrote 38.3% of opioid prescriptions in 2012**
  - **Primary care prescribed 54%, ED/Urgent Care 20%, Psychiatry 11%, Surgery 8%, Dentistry 4%, Pain Management 3% (San Diego analysis of ODs from CURES)**

The Science of Opioids Has Changed

OLD NEWS: What we were taught 10-15 years ago	**CURRENT SCIENCE and FACTS**
• Opioids are safe and effective for chronic pain • Prescription opioids rarely lead to addiction (<1%) • Prescription opioids do not lead to other illicit drugs • There is no limit to the daily dose of opioids for chronic pain • Physicians are needlessly allowing patients to suffer because of "opiophobia"	• Long term opioids change the brain, often permanently (severe dopamine depletion) • Addiction/dependency to prescription opioids is common in general practice: 10-26% • Short term opioids lead to chronic use after even 7 to 30 days • OD and Deaths from prescription opioids are dose dependent o Adjusted Hazard Rate for Unintentional OD (MME = mg's morphine equivalent) ▪ 1.44 for 20-49 MME/day ▪ 3.73 for 50-99 MME/day ▪ 8.87 for ≥ 100 MME/day • Combination of Opioids with Benzodiazepines and/or carisoprodol (Soma)increases risk of respiratory depression and death



MORE from the latest EVIDENCE-BASED REVIEWS from AHRQ (2014) and CDC (2016):

Summary:

- No evidence shows a long-term benefit of opioids in pain and function for non-cancer chronic pain with outcomes examined at least 1 year later (with most placebo-controlled randomized trials < 6 weeks in duration).
- Extensive evidence shows the possible harms of opioids (including abuse and dependence, overdose, myocardial infarction, motor vehicle crashes).
- Extensive evidence suggests benefits of alternative treatments compared with long-term opioid therapy, including non-pharmacologic therapy and non-opioid pharmacologic therapy, with less harm.

Additional Details and recommendations:

- Continuing opioids for 3 months (90d) substantially increases risk of OUD (opioid use disorder)
- If no pain relief in 1 month (30 days), unlikely to experience pain relief with opioids at 6 months
- Long-term opioid use often begins with treatment of acute pain.
    - When opioids are used for acute pain, providers should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three or fewer days usually will be sufficient for most nontraumatic pain not related to major surgery (CDC 2016 recommendation category: A, evidence type: 4).
- When opioids are started, providers should prescribe the lowest effective dosage.
    - Providers should use caution when prescribing opioids at any dosage, should implement additional precautions when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should generally avoid increasing dosage to ≥90 MME/ day (CDC 2016 recommendation category: A, evidence type: 3).

Four Evidence-Based Strategies to Safer Prescribing

1. Not on chronic opioids?
    - Acute Pain: Don't Start. Use alternatives, or judicious, short-term immediate release opioids
    - Chronic non-cancer pain: Don't start. Use alternatives
2. On opioids?
    - Taper to lower, safer doses --- less than 50- 100 milligram morphine equivalents a day
3. Treat addiction with effective medications and counseling
4. Increase availability and access to naloxone

Emergency Department Safe Opioid Prescribing Guidelines as a Template for Urgent Care Practice

The American Academy of Emergency Medicine (AAEM) and the American College of Emergency Physicians (ACEP) have evaluated the latest evidence and practice patterns and developed Safe Prescribing Opioid Guidelines (see below).

The California Chapter of ACEP has joined with the LA County SafeMedLA Coalition, along with other county coalitions in California (San Diego, Imperial, Ventura, etc.) to advocate adoption and implementation of the AAEM guidelines and patient communications in all EDs.

Clinical Practice Statement – American Academy of Emergency Medicine

Emergency Department Opioid Prescribing Guidelines for the Treatment of Non-Center Related pain (11/12/2013)

Recommendations

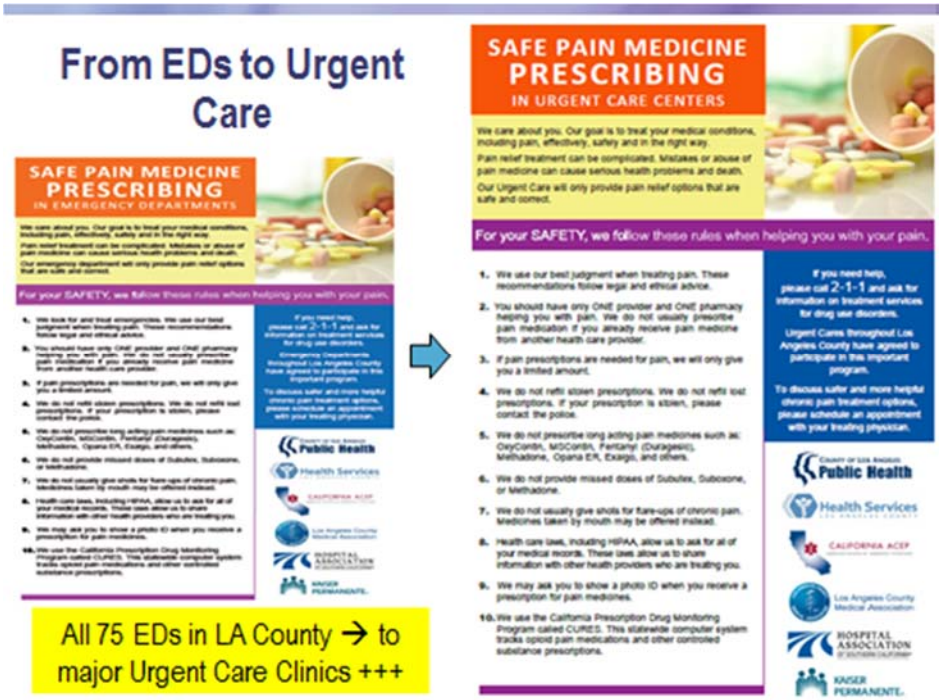
In the management of the emergency department patient presenting with acute or chronic pain, the emergency clinician should consider the following when prescribing an opioid medication:

1. Administer a short-acting opioid analgesic for the treatment of acute pain as a second-line treatment to other analgesics unless there is a clear indication for the use of opioid medication (Example-patient with acute abdomen, long bone fracture, etc).
2. Start with the lowest effective dose of an opioid analgesic.
3. Prescribe a short course (up to 3 days) of opioid medication for most acute pain conditions.
4. Address exacerbations of chronic pain conditions with non-opioid analgesics, non-pharmacological therapies, or referral to pain specialists for follow-up.
5. Consider assessing for opioid misuse or addiction using a validated screening tool.
6. Consider accessing a centralized prescription network or state-based prescription drug monitoring program, when available, for patient information on recent controlled substance prescriptions.
7. Refrain from initiating treatment with long-acting, or extended-release, opioid analgesics such as methadone.
8. Avoid prescribing opioid analgesics to patients currently taking sedativehypnotic medications or concurrent opioid analgesics.
9. Refrain from replacing prescriptions for lost, stolen, or destroyed opioid prescriptions.
10. Refrain from refilling chronic opioid prescriptions. Refer the patient to the treating clinician who provided the original prescription.
11. Encourage prescribers to provide safety information about opioid analgesics to patients. This could include information on the risks of overdose, dependence, addiction, safe storage, and proper disposal of unused medications.
12. Following treatment with opioids (in particular the parenteral form) consider an appropriate period of observation and monitoring before a patient is discharged.
13. Understand EMTALA and its requirements for the treatment of pain. The emergency clinician is required under EMTALA to evaluate an emergency department patient reporting pain. The law allows the emergency clinician to use clinical judgment when treating pain and does not require the use of opioids.

- In LA County, all 75 EDs have adopted the guidelines and using the patient communications materials (2014-2015)
- Goals and expected outcomes:
    - Consistent community standard of practice
    - Reduced doctor shopping for opioids
    - Reduced opioid over-prescribing, overuse, misuse, abuse, diversion, OD, and deaths
    - Better evidence-base pain management and addiction management through re-direction to primary care, pain management, and addiction medicine services

Safe Med LA URGENT CARE CENTER Goal for 2016:

Expand the same initiative to LA County Urgent Care Centers: adapt, adopt, and implement the AAEM guidelines and patient information communications



Be Part of the Solution and not part of the problem of Opioid Over-Prescribing

What YOU Can Do:

- ***Recognize the community epidemic*** *of unintentional overdoses and deaths due to the over-prescribing of prescription opioids and* ***join with the LA County collaborative***
- ***Use your leadership, influence, and leverage to:***
  - ***Adopt consistent community-wide clinical guidelines for safe opioid prescribing in EDs and Urgent Care Centers***
  - ***Adopt consistent patient/consumer messaging (Pt Handout)***

The Status of Prescription Drug Abuse in Los Angeles County: 2008-2013

Prescription drug abuse has become one of the fastest-growing public health concerns in the United States and Los Angeles County (LAC). The number of deaths from prescription opioids now exceeds the combined number of deaths involving heroin and cocaine. Health care providers can play a significant role in addressing this growing problem. Thus, the LAC Prescription Drug Abuse Medical Task Force, a multi-disciplinary coalition, was formed to develop common principles among all 81 LA county Emergency Departments on the safe use of opioid pain medications.

This Score Card reviews the scale of the prescription drug abuse problem in Los Angeles County by looking at multiple factors and data points over the last six years. Readers are encouraged to look at all of the information as well as the direction of the trends over time.

Los Angeles County Prescription Drug (Rx) Abuse 2008-2013 Score Card

	INDICATOR	2008	2009	2010	2011	2012	2013
1	**Rx Opioid-Related Deaths**[1]						
	• Number	424	434	360	386	381	Pending
	• Rate Per 100,000 residents	4.3	4.4	3.7	3.9	3.8	
2	**Rx-Related Emergency Dept. Visits**						
	• Number	3,939	4,472	5,531	5,838	Pending	
	• Rate Per 100,000 residents	40.3	45.4	56.3	59.1		
3	**Rx-Related Hospitalizations**						
	• Number	3,375	3,394	3,727	3,600		
	• Rate Per 100,000 residents	34.5	34.5	37.9	36.4		
4	**Primary Rx Treatment Admissions**						
	• Number	1,048	1,192	1,241	1,114	1,743	Pending
	• Rate Per 100,000 residents	10.7	12.1	12.6	11.3	17.5	
5	**Rx Misuse among Students (Life Time)** [2]						
	• 9th graders	N/A	11%	11%	11%	N/A	11%
	• 11th graders		15%	16%	14%		15%
6	**Pharmacy Robberies/Burglaries**	N/A	64	31	63	61	Pending
7	**Pounds of Safely Disposed Medications**						
	• Take Back Events	N/A		2,935	16,965	19,064	22,657
	• Sheriff Dept. Collection Boxes		4,113	9,546	10,295	20,679	Pending
8	**Rx Pill Counts**						
	Opioids[3] • Per resident	Pending			26	25	Pending
	• Per prescription				61	60	
	Sedatives • Per resident				18	17	
	• Per prescription				44	44	
	Stimulants • Per resident				3	4	
	• Per prescription				57	55	

1. Rx opioid-related deaths include the number of drug-related deaths that tested positive for Rx opioids. Many of these deaths tested positive for multiple substances and it is not possible to determine if the Rx opioid was actually the cause of death. drug deaths testing positive for prescription opioids.
2. California Healthy Kids Survey is administered for two-school year period. For example, the 2009 data in this table is aggregated for both 2007-2008 and 2008-2009 school year survey data.
3. Opioids include only pills; solution-based and liquid-type prescriptions were not included in the count.

Additional Statistics on Prescription Drug (Rx) Indicators

Drug Treatment

Data on the publicly funded treatment admissions in Los Angeles County reflect the availability of treatment, which varies according to funding and other factors. Thus, they don't necessarily reflect total treatment needs among all drug users.

Figure 1: Percent of Primary Drug of Choice for Admissions to Los Angeles County Publicly Funded Treatment Programs

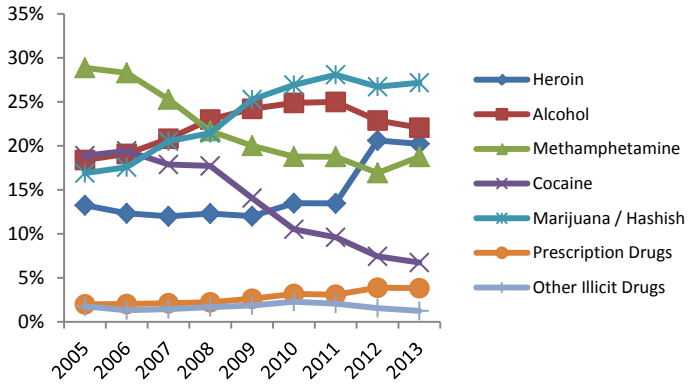
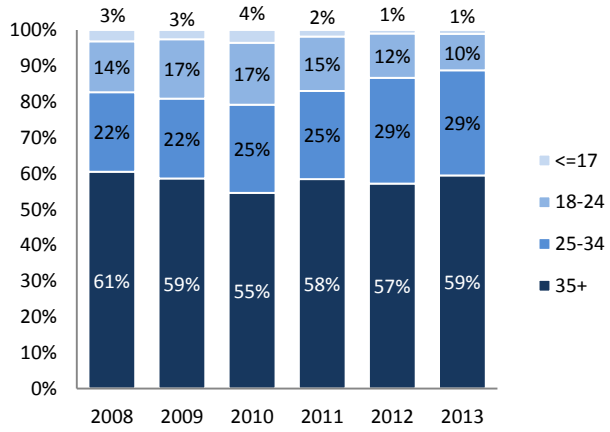


Figure 2: Primary Rx Treatment Admissions by Age



Percent of heroin treatment admissions have been increasing for the last two years (Figure 1). Prescription drug treatment admissions were most common among persons aged 35 and older, but have been increasing among persons aged 25-34 (Figure 2). LACPRS data, however, likely underestimate the number of prescription drug treatment admission episodes in Los Angeles County because they do not include data from privately funded treatment programs.

Figure 3:
Multi-Drug Detected in Drug Related Deaths in Los Angeles County, 2000-2012

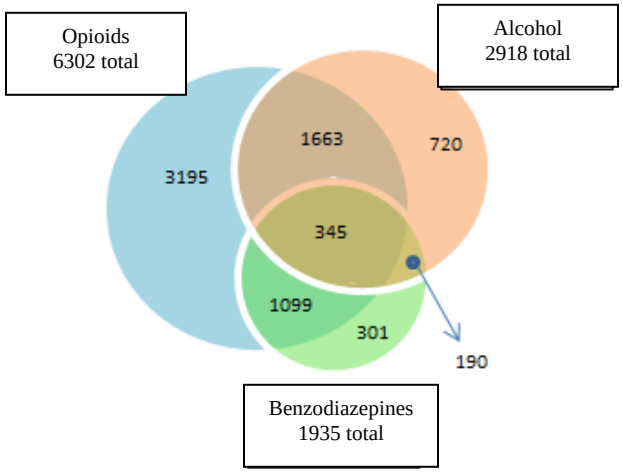


Figure 3 displays data for 13 years of drug related deaths, and shows how prescription opioids are frequently combined with other drugs. This is important because opioids have additive effects when combined with other substances such as alcohol and benzodiazepines;, potentially increasing respiratory depression and increased risk for overdose death. Almost half of the deaths testing positive for opioids during this time involve combinations with either alcohol or benzodiazepines or both.

Drug Retail Price

A large variety of pills are sold and the price often depends on the amount bought. Overall the average prices remain stable: Vicodin 10mg. per tablet sold for $1-5 in 2008 and $3 in 2013. Xanax 4mg. per pill sold for $1-2 in 2012 and $2-5 in 2013. However, the price of Oxycontin pill (80mg.) dropped significantly from $80 in 2009 to $10-14 in 2013. This may be because of an effort to capture existing Oxycontin users, and prevent them from switching to Black Tar Heroin, which is cheaper than a single Oxycontin pill.

Heroin Addendum

Heroin abuse is growing nationwide. In LAC, heroin seizures have increased between 2008 and 2010 and heroin treatment admissions increased in 2012. There is speculation that the prescription drug abuse epidemic may be contributing to this trend, as users switch to the cheaper heroin after prescription opioids become harder to find and more expensive. According to LA CLEAR, Mexican Black Tar heroin prices have dropped slightly starting since the spring of 2012. This is believed to be the Mexican Drug Trafficking Organizations' efforts to expand their heroin market by appealing to former Oxycontin Users in affluent areas. Other indicators of the heroin problem are listed below.

Los Angeles County Heroin Abuse 2008-2013							
	INDICATOR	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
1	**Heroin-Related Deaths**[4]						
	• Number	244	223	196	226	186	Pending
	• Rate Per 100,000 residents	2.5	2.3	2.0	2.3	1.9	
2	**Primary Heroin Treatment Admissions**						
	• Number Rate	5,781	5,458	5,273	4,862	9,259	Pending
	• Rate Per 100,000 residents	59.1	55.4	53.7	49.2	93.0	
3	**Heroin Use among Students** (Life Time)[2]						
	• 9th graders	N/A	3%	4%	4%	N/A	3%
	• 11th graders		3%	4%	3%		2%
4	**Heroin Seizures (Kgs)**						
	• Los Angeles County	63	149	254	Pending		
5	**Heroin Retail Price per Gram**						
	• Mexican Black Tar Heroin	$80	$80	$80	$80	$60-100	$55-100

Figure 1: Primary Heroin Treatment Admissions, by Age

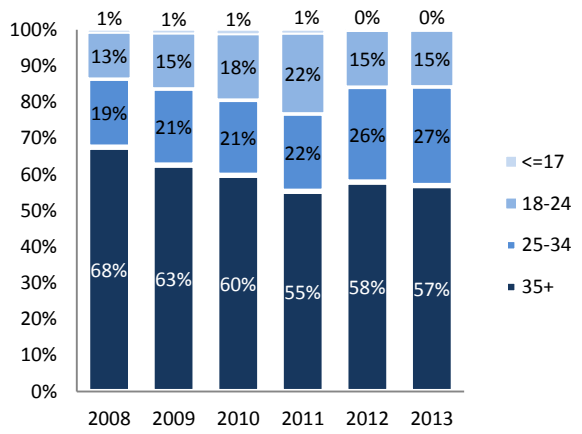
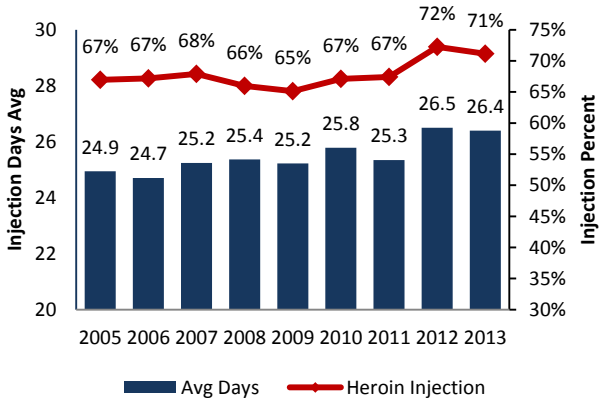


Figure 2: Heroin Injection Experience in the Past 30 Days among Clients who Reported Heroin as a Primary Drug of Problem



Heroin treatment admission rates have been increasing among persons aged 25-34, but have decreased among persons aged 35 and older (Figure 1). Heroin injection rates and days of injection among clients who reported heroin as a primary drug of problem have slightly increased during the last two years (Figure 2).

4. Heroin-related deaths include drug related deaths that test positive for heroin (6-monoacetylmorphine) and drug-related deaths that test positive for morphine along with a mention of heroin in one of the descriptive variables about the death. This is because heroin metabolizes very quickly to morphine, so this method provides a more accurate count of heroin-related deaths.

Looking Forward

The LAC Prescription Drug Abuse Medical Task Force will continue collecting data to inform priorities for action. The Task Force has developed the safe opioid pain medication prescribing guidelines and language and communication tools for patients (handouts and posters); and will also track implementation of the use of handout and outcomes (e.g., number of opioid prescriptions, patient satisfaction). This County-wide approach is intended to decrease doctor and Emergency Department shopping, increase provider and patient education, and ensure that safer care is provided for patients suffering from chronic pain.

Become Involved in Keeping Los Angeles County Healthy, Safe and Thriving

You can make a difference!

- ✓ Safely dispose of your old prescriptions at a Take Back Event or local LA County Sheriff's Safe-Drug Drop-Off Boxes (http://www.deadiversion.usdoj.gov/drug_disposal/index.html; http://shq.lasdnews.net/content/uoa/SHB/SafeDrugDropOff.pdf)
- ✓ Keep track of your medicine and secure it.
- ✓ Don't share your own medications, or use medications prescribed to someone else.
- ✓ Share this information and talk to your family members and neighbors about the risks involved with the misuse of prescription drugs.

Type and Source for Score Card Indicators

1. Rx opioid and heroin related deaths and interaction among substance detected in drug related death. *Source*: Los Angeles County Coroner Data, Drug Related Death Surveillance System, Injury and Violence Prevention Program.

2-3. Rx related Emergency Department visits and hospitalizations. *Source*: Office of Statewide Health Planning and Development, Emergency Department and Hospital Discharge Data, 2008-2011.

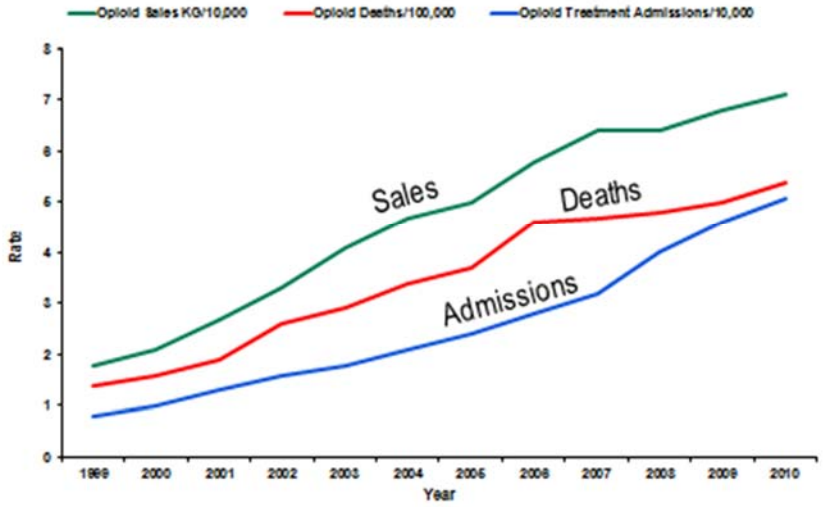
4. Primary Rx and heroin treatment admissions and injection experience. *Source*: Los Angeles County Participant Reporting System data, Los Angeles County Department of Public Health, Substance Abuse Prevention and Control.
5. Rx and heroin misuse among students. *Source*: Los Angeles County. California Healthy Kids Survey. 2008-13; Main Report San Francisco: WestEd Health and Human Development Program for the California Department of Education.
6. Pharmacy Robberies/Burglaries. *Source*: Drug Enforcement Administration (DEA).
7. Pounds of safely disposed medications at Rx Tack Back Events. *Source*: DEA. Pounds collected at Sheriff Dept. Safe-Drug Drop-Off Boxes. *Source*: Los Angeles County Sheriff's Department.
8. Rx pill counts. *Source*: Department of Justice, California Controlled Substance Utilization Review and Evaluation System (CURES)/Prescription Drug Monitoring Program (PDMP) data.

Note: The heroin seizures and Rx/heroin retail price information source: LA CLEAR: Los Angeles Regional Criminal Information Clearinghouse.

Thank you to our partners at the San Diego Prescription Drug Abuse Task Force who provided guidance in creating this Score Card.

UNITED STATES HEALTH STATISTICS:

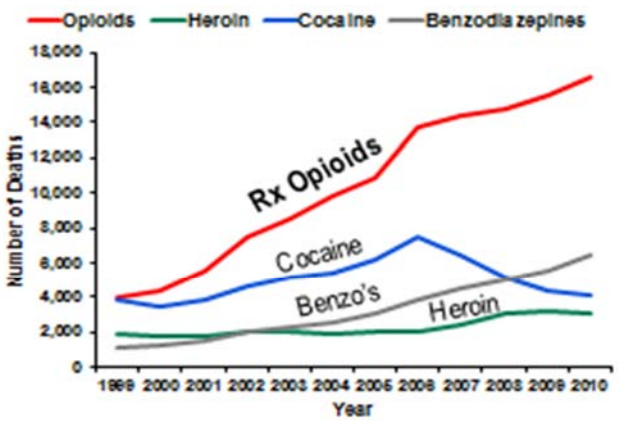
Rates of Opioid Overdose Deaths, Sales, and Treatment Admissions, United States, 1999–2010



1. CDC. MMWR 2011.
2. Source: Pain and Policy Studies Group, University of Wisconsin School of Medicine and Public Health.
3. Manchikanti L, Singh A. Therapeutic opioids: a ten-year perspective on the complexities and complications of the escalating use, abuse, and nonmedical use of opioids. 2008 Mar;11(2 Suppl):S63-88.

Number of Unintentional Drug Overdose Deaths Involving Opioids, Cocaine, and Heroin, 1999–2010

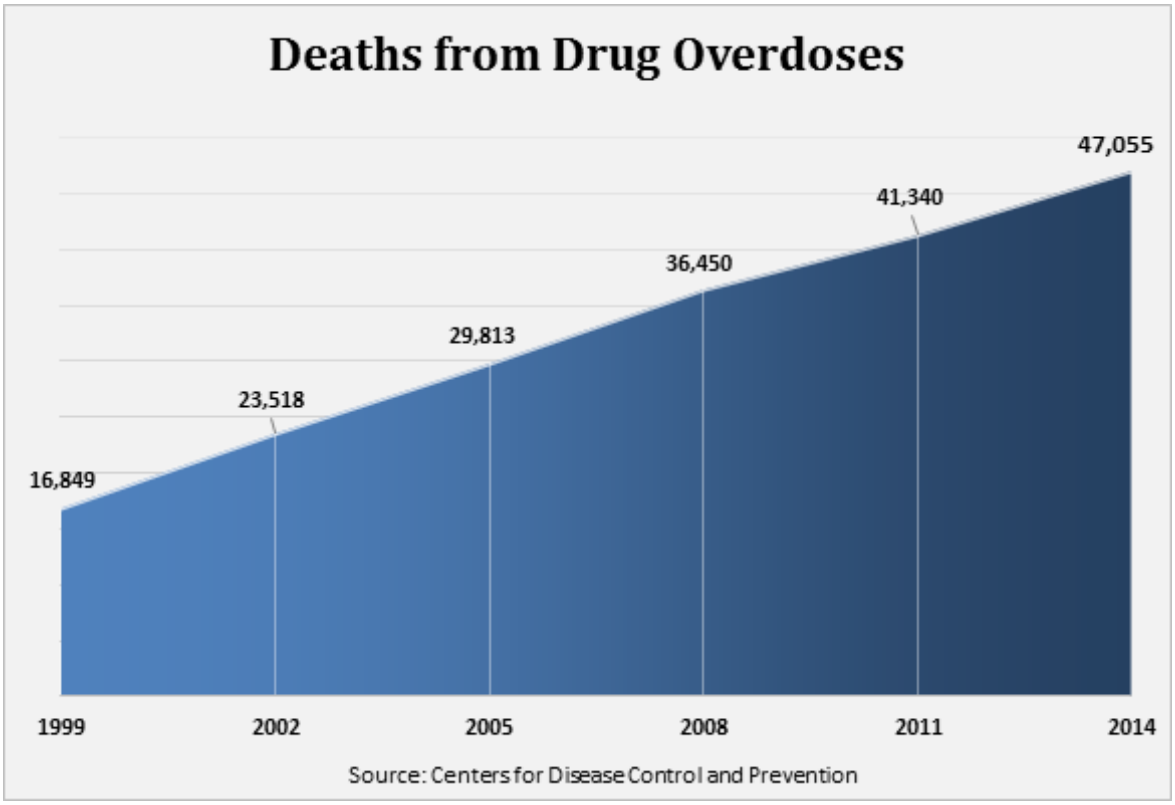
FIGURE 2. Number of unintentional drug overdose deaths involving opioid analgesics, cocaine, and heroin — United States, 1999-2010



Source: National Vital Statistics System. Multiple cause of death dataset. Available at http://www.cdc.gov/nchs/nvss.htm.

More deaths from prescription Opioids than heroin, cocaine, and benzo's combined

46 people die every day in US from unintentional prescription opioid over-prescribing



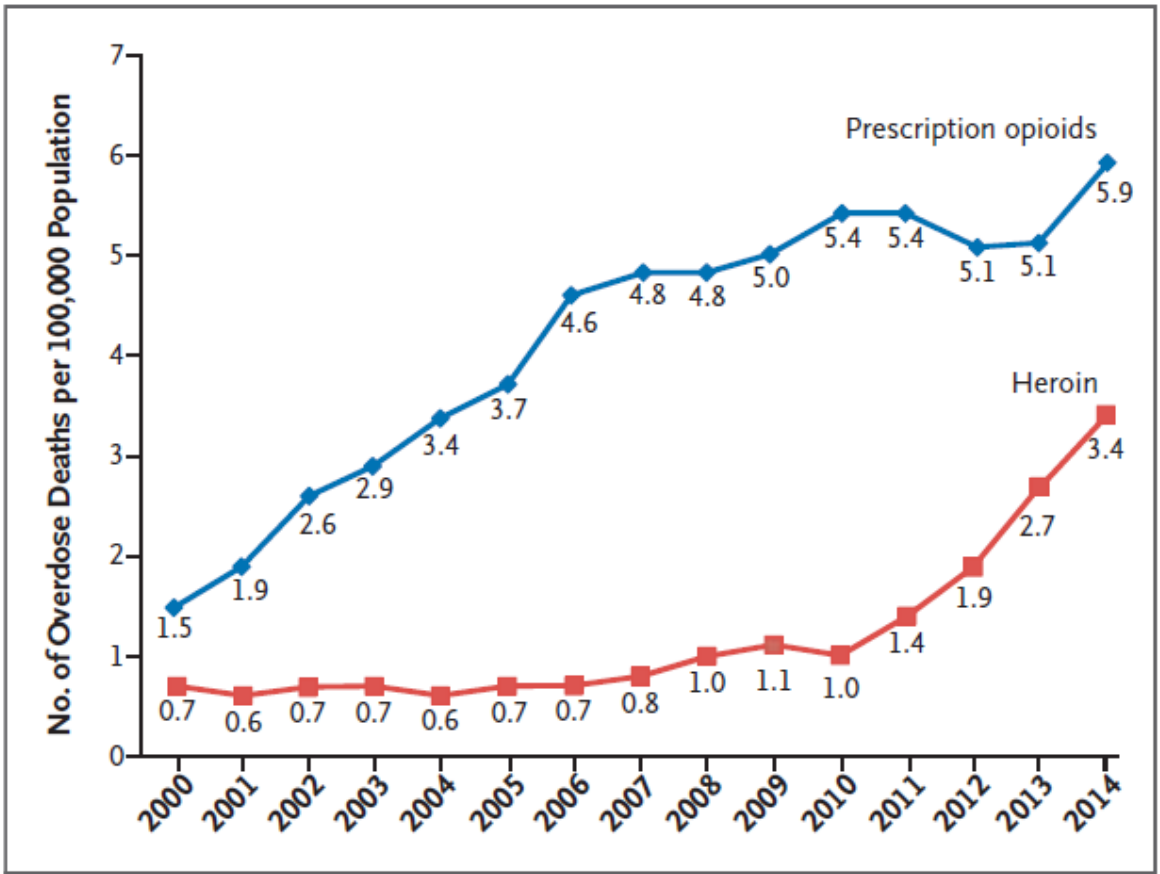
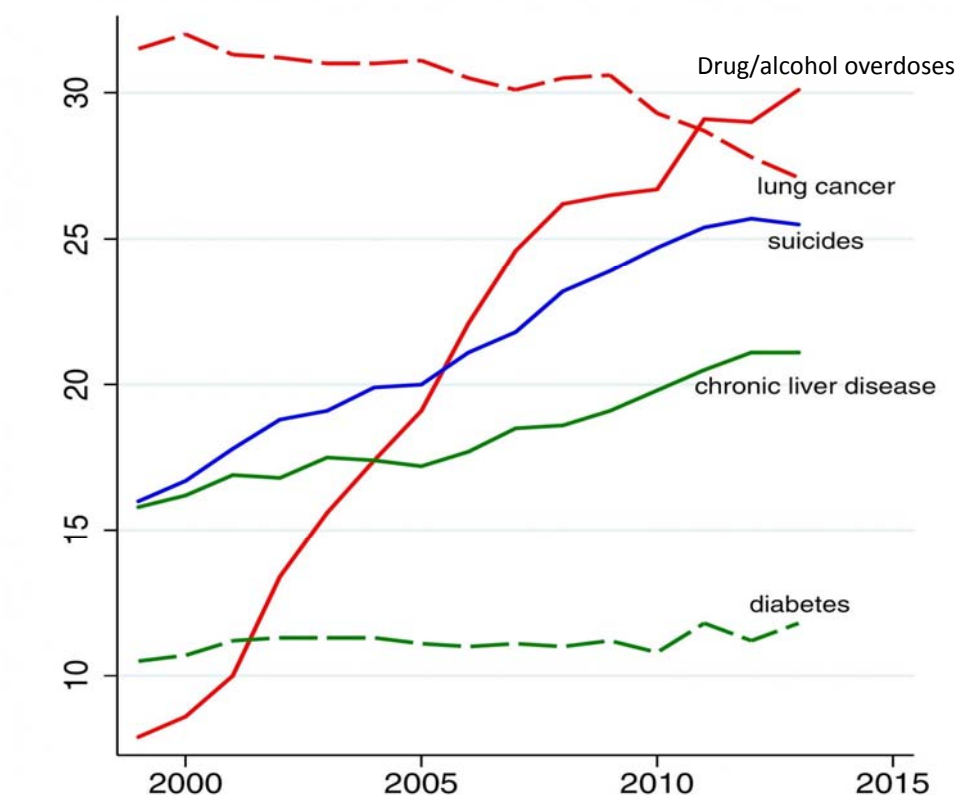


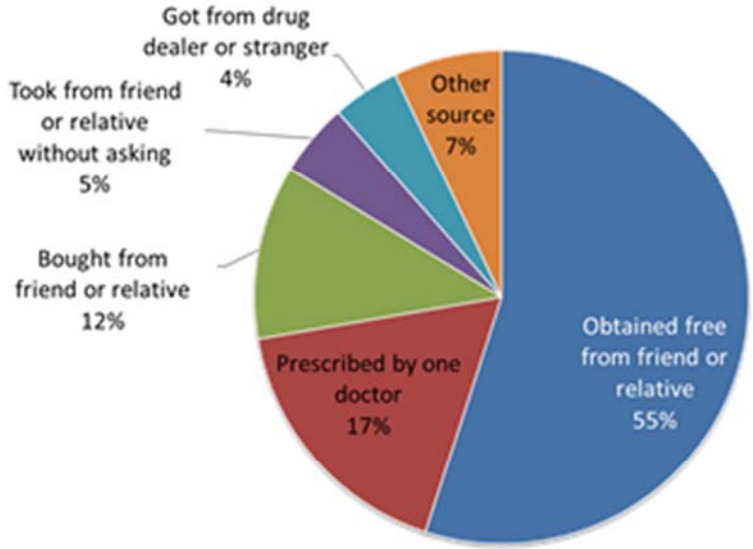
Figure 1. Age-Adjusted Rates of Death Related to Prescription Opioids and Heroin Drug Poisoning in the United States, 2000–2014.

Data are from the Centers for Disease Control and Prevention.[5]

Mortality by cause for white non-Hispanics, 45 to 54 age group, per 100,000 people

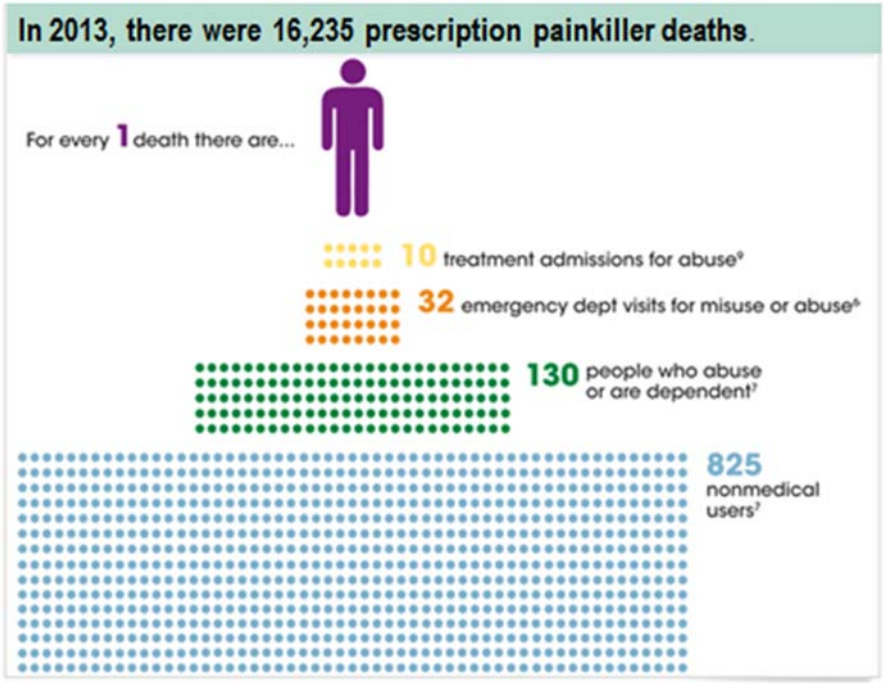


People who abuse prescription painkillers get drugs from a variety of sources (Source: CDC)



72% of people who abuse prescription painkillers get them from a friend or relative

http://www.cdc.gov/homeandrecreationalsafety/rxbrief
http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm#2.16



Morbidity and Mortality Weekly Report (*MMWR*)
Early Release
December 18, 2015 / 64(Early Release);1-5

Increases in Drug and Opioid Overdose Deaths — United States, 2000-2014

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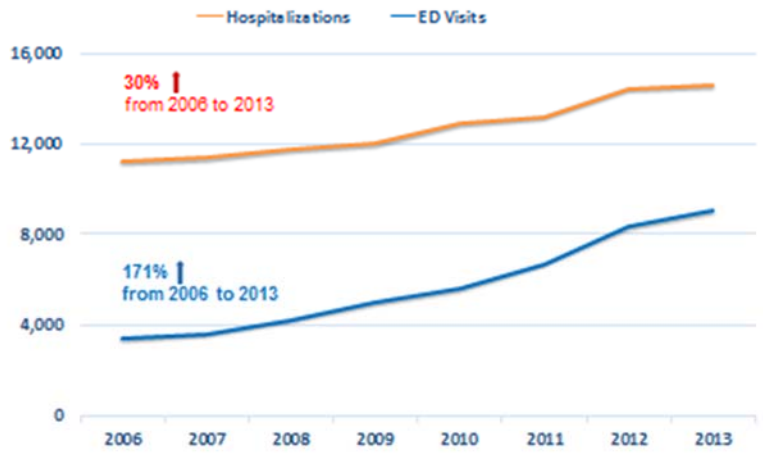
The United States is experiencing an epidemic of drug overdose (poisoning) deaths. Since 2000, the rate of deaths from drug overdoses has increased 137%, including a 200% increase in the rate of overdose deaths involving opioids (opioid pain relievers and heroin). CDC analyzed recent multiple cause-of-death mortality data to examine current trends and characteristics of drug overdose deaths, including the types of opioids associated with drug overdose deaths. During 2014, a total of 47,055 drug overdose deaths occurred in the United States, representing a 1-year increase of 6.5%, from 13.8 per 100,000 persons in 2013 to 14.7 per 100,000 persons in 2014. The rate of drug overdose deaths increased significantly for both sexes, persons aged 25–44 years and ≥55 years, non-Hispanic whites and non-Hispanic blacks...

Between 2013 and 2014, the age-adjusted rate of death involving methadone remained unchanged; however, **the age-adjusted rate of death involving natural and semisynthetic opioid pain relievers, heroin, and synthetic opioids, other than methadone (e.g., fentanyl) increased 9%, 26%, and 80%, respectively.**

LOS ANGELES COUNTY:

County of Los Angeles Public Health

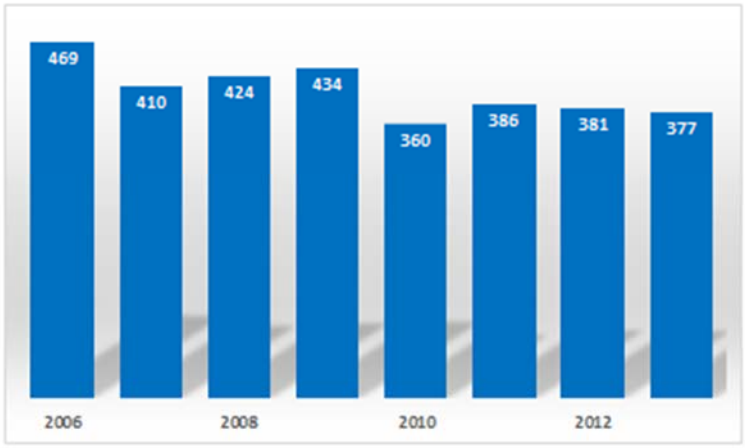
Opioid-Related ED Visits and Hospitalizations in LAC



Emergency Department and Inpatient Discharge Data Set. Office of Statewide Health Planning and Development. California Department of Public Health.

County of Los Angeles Public Health

Opioid-Related Deaths in LAC, 2000-2013



Emergency Department and Inpatient Discharge Data Set. Office of Statewide Health Planning and Development. California Department of Public Health.

Emergency Department and Urgent Care Center Addresses

This section of the toolkit provides addresses for Los Angeles County Emergecny Departments and Urgent Care Centers.

Facility Name	Street	City	State	ZipCode
Alhambra Hospital Medical Center	100 So. Raymond Avenue	Alhambra	CA	91801-
Antelope Valley Hospital Medical Center	1600 West Avenue J	Lancaster	CA	93534-
Beverly Hospital	309 W. Beverly Blvd.	Montebello	CA	90640-
California Hospital Medical Center	1401 S Grand Avenue	Los Angeles	CA	90018-
Catalina Island Medical Center	100 Falls Canyon Road	Avalon	CA	90704-
Cedars Sinai Medical Center	8700 Beverly Blvd.	Los Angeles	CA	90048-
Centinela Hospital Medical Center	555 E Hardy Street	Inglewood	CA	90301-
Children's Hospital of Los Angeles	4650 Sunset Blvd.	Los Angeles	CA	90027-
Citrus Valley Medical Center-Intercommunity Campus	210 W. San Bernardino Road	Covina	CA	91723-
Citrus Valley Medical Center-Queen of the Valley	1115 S. Sunset Avenue	West Covina	CA	91790-
Coast Plaza Doctors Hospital	13100 Studebaker Rd.	Norwalk	CA	90650-
College Medical Center	2776 Pacific Avenue	Long Beach	CA	90806-
Community Hospital of Huntington Park	2623 E Slauson Ave	Huntington Park	CA	90255
Community Hospital of Long Beach	1720 Termino Avenue	Long Beach	CA	90804-
East Los Angeles Doctors Hospital	4060 Whittier Blvd.	Los Angeles	CA	90023-
East Valley Hospital Medical Center	150 W. Route 66	Glendora	CA	91740-
Encino Hospital Medical Center	16237 Ventura Blvd.	Encino	CA	91436-
Foothill Presbyterian Hospital	250 S Grand Ave.	Glendora	CA	91741
Garfield Medical Center	525 N. Garfield Avenue	Monterey Park	CA	91754-
Glendale Adventist Medical Center	1509 Wilson Terrace	Glendale	CA	91206-
Glendale Memorial Hospital	1420 South Central Avenue	Glendale	CA	91204-
Good Samaritan Hospital	1225 Wilshire Blvd.	Los Angeles	CA	90017-
Greater El Monte Community Hospital	1701 Santa Anita Avenue	South El Monte	CA	91733-
Harbor - UCLA Medical Center	1000 W Carson Street	Torrance	CA	90502-
Henry Mayo Newhall Memorial Hospital	23845 West McBean Parkway	Valencia	CA	91355-
Hollywood Presbyterian MC	1300 N Vermont Ave	Los Angeles	CA	90027-
Huntington Memorial Hospital	100 W. California Blvd.	Pasadena	CA	91105-
Kaiser Permanente - Downey	9333 Imperial Hwy	Downey	CA	90242-
Kaiser Permanente - Woodland Hills	5601 De Soto Ave.	Woodland Hills	CA	91365-
Kaiser Permanente Baldwin Park Medical Center	1011 Baldwin Park Blvd.	Baldwin Park	CA	91706-
Kaiser Permanente Hospital - Panorama City	13652 Cantara Street	Panorama	CA	91402-

Facility Name	Street	City	State	ZipCode
Kaiser Permanente Hospital-South Bay Medical Center	25825 S Vermont Avenue	Harbor City	CA	90710-
Kaiser Permanente Los Angeles Medical Center	4867 Sunset Blvd.	Los Angeles	CA	90027-
Kaiser Permanente West LA	6041 Cadillac Ave.	Los Angeles	CA	90034-
LAC+USC Medical Center	1200 N. State St.	Los Angeles	CA	90033-
Lakewood Regional Medical Center	3700 E. South Street	Lakewood	CA	90712-
Long Beach Memorial Medical Center	2801 Atlantic Avenue	Long Beach	CA	90806-
Los Angeles Community Hospital of LA and Norwalk	4081 E. Olympic Blvd.	Los Angeles	CA	90023-
Marina Del Rey Hospital	4650 Lincoln Blvd	Marina Del Rey	CA	90292-
Memorial Hospital of Gardena	1145 W Redondo Beach Blvd	Gardena	CA	90247-
Methodist Hospital of Southern California	300 W. Huntington Dr.	Arcadia	CA	91007-
Miller Children's Hospital*	2801 Atlantic Avenue	Long Beach	CA	90806-
Mission Community Hospital	14850 Roscoe Blvd.	Panorama	CA	91402-
Monterey Park Hospital	900 S. Atlantic Blvd.	Monterey Park	CA	91754-
Northridge Hospital Medical Center	18300 Roscoe Blvd.	Northridge	CA	91328-
Norwalk Community Hospital	13222 Bloomfield Ave	Norwalk	CA	90650-
Olive View - UCLA Medical Center	14445 Olive View Drive	Sylmar	CA	91342-
Olympia Medical Center	5900 West Olympic Blvd.	Los Angeles	CA	90036-
Pacifica Hospital of the Valley	9449 San Fernando Road	Sun Valley	CA	91352-
Palmdale Regional Medical Center/Lancaster Community Hospital	38600 Medical Center Drive	Palmdale	CA	93551-
PIH Health Hospital - Downey	11500 Brookshire Ave	Downey	CA	90241-
Pomona Valley Hospital Medical Center	1798 N. Garey Ave.	Pomona	CA	91767-
Presbyterian Intercommuity Hospital	12401 E. Washington Blvd.	Whittier	CA	90602-
Providence Holy Cross Medical Center	15031 Rinaldi Street	Mission Hills	CA	91345-
Providence Little Company of Mary Medical Center - Torrance	4101 Torrance Blvd	Torrance	CA	90503-
Providence Little Company of Mary Medical Center-San Pedro	1300 West Seventh Street	San Pedro	CA	90732-
Providence Saint John's Health Center	2121 Santa Monica Blvd.	Santa Monica	CA	90404-2091
Providence Saint Joseph Medical Center	501 South Buenavista Street	Burbank	CA	91505-
Providence Tarzana Regional Medical Centers	18321 Clark Street	Tarzana	CA	91356-
Ronald Reagan UCLA Medical Center	757 Westwood Plaza	Los Angeles	CA	90095-
Saint Francis Medical Center	3630 E Imperial Highway	Lynwood	CA	90262-
Saint Mary Medical Center Long Beach	1050 Linden Avenue	Long Beach	CA	90813-
Saint Vincent Medical Center	2131 West 3rd St.	Los Angeles	CA	90057-

Facility Name	Street	City	State	ZipCode
San Dimas Community Hospital	1350 W. Covina Blvd.	San Dimas	CA	91773-
San Gabriel Valley Medical Center	438 W. Las Tunas Dr.	San Gabriel	CA	91776-
Santa Monica-UCLA MC and Orthopedic Hospital	1250 16th St.	Santa Monica	CA	90404-
Sherman Oaks Hospital	4929 Van Nuys Blvd.	Sherman Oaks	CA	91403-
Southern California Hospital at Culver City/ Hollywood Community Hospital at Brotman	3828 Delmas Terrace	Culver City	CA	90232-
Torrance Memorial Medical Center	3330 Lomita Blvd	Torrance	CA	90505-
Gardens Regional Hospital and Medical Center	21530 S. Pioneer Blvd	Hawaiian Gardens	CA	90716-
USC Verdugo Hills Hospital	1812 Verdugo Blvd	Glendale	CA	91208-
VA West LA Medical Center (Greater Los Angeles)	11301 Wilshire Blvd.	Los Angeles	CA	90073-
Valley Presbyterian	15107 Vanowen St.	Van Nuys	CA	91405
Veterans Affairs Medical Center- Long Beach*	5901 E Seventh Street	Long Beach	CA	90822-
West Hills Hospital and Medical Center	7300 Medical Center Drive	West Hills	CA	91307-
White Memorial Medical Center	1720 E. Cesar E. Chavez Ave	Los Angeles	CA	90033-
Whittier Hospital Medical Center	9080 Colima Road	Whittier	CA	90605-

Urgent Care Center Name	Address	City	State	Zip	Contact numbers
ALTAMED MED GRP	4650 W SUNSET BLVD MS76	LOS ANGELES	CA	90027	323-669-2113
ALTAMED MED GRP - Bell	6901 Atlantic Ave.	Bell	CA	90201	888-499-9303
ALTAMED MED GRP - Boyle Heights	3945 Whittier Blvd.	LOS ANGELES	CA	90023	888-499-9303
ALTAMED MED GRP - Commerce	5427 Whittier Blvd.	LOS ANGELES	CA	90022	888-499-9303
ALTAMED MED GRP - El Monte	10418 Valley Blvd. Ste B	EL MONTE	CA	91731	888-499-9303
ALTAMED MED GRP - Pico Rivera (Slauson)	9436 E. Slauson Ave.	Pico Rivera	CA	90660	562-949-6069
ALTAMED MED GRP - West Covina	1300 S. Sunset Ave.	West Covina	CA	91790	626-960-6999
AME Medical Group	1440 N. Harbor Blvd. #100	Fullerton	CA	92835	714-451-2230
AME Medical Group	8500 Florence Ave. Ste 101	Downey	CA	90241	562-261-5944
AME MED GRP INC	11942 PARAMOUNT BLVD B	DOWNEY	CA	90242	562-923-6060
Antelope Valley Community Clinic	45104 10th St. West	Lancaster	CA	93534	661-942-2391
BRENTVIEW MED INC	11611 SAN VICENTE BLVD	LOS ANGELES	CA	90049	310-820-0013
BRENTVIEW MED INC	8264 Santa Monica Blvd.	WEST HOLLYWOOD	CA	90046	323-522-2222
Care1st Primary & Urgent Care	44426 10th St W.	Lancaster	CA	93534	661-948-2400
Care1st Primary & Urgent Care	833 Auto Center Dr, Ste D	Palmdale	CA	93551	662-273-2400
CEDARS SINAI MED CARE FOUNDATION	10100 CULVER BLVD E	CULVER CITY	CA	90232	310-423-3333
CEDARS SINAI MED CARE FOUNDATION	8501 WILSHIRE BLVD 150	BEVERLY HILLS	CA	90211	310-248-7000
COLONY CARE PARTNERS A MED GRP	23656 PACIFIC CST HWY	MALIBU	CA	90265	310-456-7551
Dusk to Dawn Urgent Care	16415 Colorado Ave. Ste 104, 306, & 307	Paramount	CA	90723	562-808-2273
DUSK TO DAWN URGENT CARE	3680 E IMPERIAL HWY 410	LYNWOOD	CA	90262	310-639-2220
DUSK TO DAWN URGENT CARE	443 S SOTO ST	LOS ANGELES	CA	90033	323-261-2273
DUSK TO DAWN URGENT CARE	701 E 28TH ST 401	LONG BEACH	CA	90806	562-426-2662
DUSK TO DAWN URGENT CARE	1045 W REDONDO BEACH 138	GARDENA	CA	90247	310-323-2273
EXer - More Than Urgent Care	701 N. Wendy Dr.	Newbury Park	CA	91320	805-375-4400
EXER MED CORP	19346 NORDHOFF ST	NORTHRIDGE	CA	91324	818-727-2040
EXER MED CORP	239 S LA CIENEGA BLVD, STE 100	BEVERLY HILLS	CA	90211	310-360-0960
EXER MED CORP	26777 AGOURA RD 4	CALABASAS	CA	91302	818-880-2225
Lakeside Community Health Care Urgent Care Center	191 S. Buena Vista St. Ste. 150	Burbank	CA	91505	818-295-5920
Facey - Mission Hills	11333 N. Sepulveda Blvd.	Mission Hills	CA	91345	818-869-7200
Facey Med Foundation	26357 McBean Pkwy 320	Valencia	CA	91355	661-222-2600
Providence Medical Institute	1010 N SEPULVEDA BLVD	MANHATTAN BEACH	CA	90266	310-376-6262
Providence Medical Institute	520 N. Prospect Ave. #102	Redondo Beach	CA	90277	310-318-9992
Providence Medical Institute	2382 Crenshaw Blvd.	Torrance	CA	90501	310-618-9200
Providence Medical Institute	1499 W. 1st St.	San Pedro	CA	90732	310-241-2590
FAMILY URGENT CAREAND INDUSTRIAL MED CLNC	16661 VENTURA BLVD 108	ENCINO	CA	91436	818-808-2828
FCS MED CORP	1701 E CESAR CHAVEZ # 230 & #402	LOS ANGELES	CA	90033	323-317-9200
FCS MED CORP	815 WASHINGTON BLVD	MONTEBELLO	CA	90640	323-728-3955
HENRY MAYO URGENT CARE CTR	23929 MCBEAN PKWY 100	VALENCIA	CA	91355	310-721-0155
HIGH DESERT MED GRP	43839 N. 15TH ST W	LANCASTER	CA	93534	661-945-5984
Healthcare Partners Long Beach UCC	2600 Redondo Ave.	LONG BEACH	CA	90806	562-988-7000
Healthcare Partners Los Angeles UCC	929 S. Georgia St.	LOS ANGELES	CA	90015	213-861-5950
HLTHCARE PARTNERS GLENDORA UCC	1365 S GRAND AVE	GLENDORA	CA	91740	626-857-2580
HLTHCARE PARTNERS MONTEBELLO UCC	2603 VIA CAMPO	MONTEBELLO	CA	90640	323-720-1144
HLTHCARE PARTNERS PASADENA UCC	797 S FAIR OAKS AVE	PASADENA	CA	91105	626-795-2244
HLTHCARE PARTNERS NORTHRIDGE UCC	18433 ROSCOE BLVD 106, 206	NORTHRIDGE	CA	91325	818-341-1540
HLTHCARE PARTNERS GV MISSION HILLS UCC	11600 Indian Hills Rd, Ste 100	MISSION HILLS	CA	91345	818-838-4500
HLTHLINE MED GRP	15211 VANOWEN ST 105	VAN NUYS	CA	91405	818-997-7711
HLTHPOINTE MED GRP INC	5345 IRWINDALE AVE	IRWINDALE	CA	91706	626-960-5361
HLTHPOINTE MED GRPINC	16702 VLY VIEW AVE	LA MIRADA	CA	90638	562-921-0341
IMPERIAL PRIMARY CARE MED GRP INC	15625 IMPERIAL HWY	LAMIRADA	CA	90638	562-902-3000
NORTHRIDGE AFTER HOURS PED URG CARE INC	10550 SEPULVEDA BLVD 101	MISSION HILLS	CA	91345	818-361-5437
NORTHRIDGE AFTER HOURS PED URG CARE INC	14608 VICTORY BLVD	VAN NUYS	CA	91411	818-361-5437
DHS Edward R. Roybal Comprehensive Health Center	245 S. Fetterly Ave.	Los Angeles	CA	90022	323-980-2731
DHS H. Claude Hudson Comprehensive Health Center	2829 South Grand Ave.	Los Angeles	CA	90007	213-744-3945
DHS Harbor-UCLA Medical Center	1000 W. Carson St.	Torrance	CA	90509	310-222-2345
DHS High Desert Regional Health Center	335 East Ave. I	Lancaster	CA	93535	661-471-4000
DHS Hubert H. Humphrey Comprehensive Medical Center	5850 S. Main St.	Los Angeles	CA	90003	323-846-4312
DHS LAC+USC Medical Center	2051 Marengo St.	Los Angeles	CA	90033	323-409-1000
DHS Long Beach Comprehensive Health Center	1333 Chestnut Ave.	Long Beach	CA	90813	562-599-2153
DHS Martin Luther King Outpatient Center	1670 E. 120th St.	Los Angeles	CA	90011	424-338-1000
DHS OliveView UCLA Medical Center	14445 Olive View Dr.	Sylmar	CA	91342	818-364-1555
DHS South Valley Health Center	38350 40th St. East	Palmdale	CA	93552	661-225-3001
MemorialCare Medical Group Urgent Care Center	31001 Rancho Viejo Rd. #200	San Juan Capistrano	CA	92675	949-582-200
MINUTECLINIC DIAGNOSTIC MED GRP OF CALI INC	14735 VENTURA BLVD	SHERMAN OAKS	CA	91403	866-389-2727
Monterey Park Medical Center	941 S. Atlantic Blvd. Ste. 101	MONTEREY PARK	CA	91754	626-458-8401
PIONEER MED GRP INC	2220 Clark Ave.	Long Beach	CA	90815	562-597-4181
PIONEER MED GRP INC	11480 BROOKSHIRE AVE 204	DOWNEY	CA	90241	562-862-2775
PREMIER FAMILY MEDICINE	1601 MONTE VISTA AVE 190	CLAREMONT	CA	91711	909-630-7938
Premier Family Medicine Associates Inc.	1770 N. Orange Grove Ave. Ste 101	Pomona	CA	91767	909-469-9494
AFFILIATES MED SPECIALTIES MED GRP INC	7345 MEDICAL CTR DR 600	WEST HILLS	CA	91307	818-347-2921
Axminster Medical Group	4314 W. Slauson Ave.	Los Angeles	CA	90043	323-293-7171
MED INST OF LITTLE	21311 MADRONA AVE 100C	TORRANCE	CA	90503	310-792-4444

PMI - Santa Clarita UC and Family Medicine	24035 Newhall Ranch Road	Santa Clarita	CA	91355	661-291-3444
Reddy Urgent Care	4288 Katella Ave.	Los Alomitos	CA	90720	562-296-8514
REDDY URGENT CARE OF LONG BEACH	123 ATLANTIC AVE	LONG BEACH	CA	90802	562-726-1383
REGAL MED GRP INC	117 E LIVE OAK AVE 101	ARCADIA	CA	91006	626-446-8492
KP Baldwin Park Medical Center	1011 Baldwin Park Blvd.	Baldwin Park	CA	91706	626-851-1011
KP Bellflower Medical Offices	9400 E. Rosecrans Ave.	Bellflower	CA	90706	800-823-4040
KP Downey Medical Center	9333 Imperial Highway	Downey	CA	90242	800-823-4040
KP Lancaster Medical Offices	43112 15th St. West	Lancaster	CA	93534	877-554-4404
KP Los Angeles Medical Center	4867 W. Sunset Blvd.	Los Angeles	CA	90027	800-954-8000
KP Normandie North Medical Office	25965 Normandie Ave.	Harbor City	CA	90710	800-780-1230
KP Orchard Medical Offices	9449 Imperial Highway	Downey	CA	90242	800-823-4040
KP Panorama City Medical Center	13651 Willard St.	Panorama City	CA	91402	818-375-2000
KP Pasadena Medical Offices	3280 Foothill Blvd.	Pasadena	CA	91107	800-954-8000
KP Santa Clarita Medical Offices	271-7 Tourney Rd.	Santa Clarita	CA	91355	888-778-5000
KP South Bay Medical Center	25825 Vermont Ave.	Harbor City	CA	90710	800-780-1230
KP West Los Angeles Medical Center	6041 Cadillac Ave.	Los Angeles	CA	90034	323-857-2000
KP Woodland Hills Medical Center	5601 De Soto Ave.	Woodland Hills	CA	91367	818-719-2000
Serra Community Medical Clinic	9375 San Fernando Rd.	Sun Valley	CA	91352	818-768-3000
SIERRA MED GRP	44469 10TH ST W	LANCASTER	CA	93534	661-945-9411
Sierra Urgent Care	39115 Trade Center Dr. Ste 130B	PALMDALE	CA	93551	661-273-9550
ST GEORGES MEDICALCLINIC	1750 E COLORADO BLVD	PASADENA	CA	91106	626-440-0097
Talbert Medical Group Walk-in Center	2925 N. Palo Verde Ave.	Long Beach	CA	90815	562-429-2473
TORRANCE MEMORIAL URGENT CARE MED GRP	22411 HAWTHORNE BLVD	TORRANCE	CA	90505	310-784-3740
TORRANCE MEMORIAL URGENT CARE MED GRP	855 MANHATTAN BEACH 101	MANHATTAN BEACH	CA	90266	310-939-7873
UCLA Playa Marina Walk-In Urgent Care Center	4650 Admiralty Way, Ste 100	Marina Del Rey	CA	90292	310-827-3700
UCLA Santa Monica Urgent Care Center	2424 Wilshire Blvd.	Santa Monica	CA	90403	310-828-4530
UCLA Woodland Hills (The Village at Westfield Topanga)	6344 Topanga Canyon Blvd. #2040	Woodland Hills	CA	91367	818-610-0292
US HLTHWORKS MED GRP PC	100 Oceangate, P245	LONG BEACH	CA	90802	562-432-2821
US HLTHWORKS MED GRP PC	1149 W 190TH ST	TORRANCE	CA	90248	310-324-5777
US HLTHWORKS MED GRP PC	1313 W 8TH ST 100	LOS ANGELES	CA	90017	213-401-1970
US HLTHWORKS MED GRP PC	150 S PICO AVE	LONG BEACH	CA	90802	562-432-2821
US HLTHWORKS MED GRP PC	16300 ROSCOE BLVD 1A	VAN NUYS	CA	91406	818-893-4426
US HLTHWORKS MED GRP PC	16630 S BROADWAY ST	GARDENA	CA	90248	310-768-8155
US HLTHWORKS MED GRP PC	17487 HURLEY ST	CITY OF INDUSTRY	CA	91744	626-965-0959
US HLTHWORKS MED GRP PC	19401 South Vermont Ave., Bldg. L	Torrance	CA	90502	310-324-5777
US HLTHWORKS MED GRP PC	22840 SOLEDAD CYN RD	SAUGUS	CA	91350	661-799-1776
US HLTHWORKS MED GRP PC	2499 S WILMINGTON AVE	COMPTON	CA	90220	310-638-1113
US HLTHWORKS MED GRP PC	25733 RYE CYN RD	VALENCIA	CA	91355	661-295-2500
US HLTHWORKS MED GRP PC	3430 GARFIELD AVE	COMMERCE	CA	90040	323-722-8481
US HLTHWORKS MED GRP PC	3851 SOTO ST	VERNON	CA	90058	323-585-7162
US HLTHWORKS MED GRP PC	390 N SEPULVEDA BLVD 1000	EL SEGUNDO	CA	90245	310-640-9911
US HLTHWORKS MED GRP PC	6520 N IRWINDALE AVE 100	IRWINDALE	CA	91702	626-812-0366
US HLTHWORKS MED GRP PC	801 CORP CTR DR 130	POMONA	CA	91768	909-623-1954
US HLTHWORKS MED GRP PC	9350 FLAIR DR 102	EL MONTE	CA	91731	626-407-0300
US HLTHWORKS MED GRP PC	9700 DE SOTO AVE	CHATSWORTH	CA	91311	818-882-8100
Van Nuys Superior Care Medical Group	6511 Van Nuys Blvd.	VAN NUYS	CA	91401	818-901-9090
VENICE CULVER MARINA MED GRP	12212 W WASHINGTON BLVD	LOS ANGELES	CA	90066	310-391-5241
Woodland Hills Medical Clinic Topanga	5995 Topanga Canyon Blvd.	Woodland Hills	CA	91367	818-888-7009
Healthcare Partners Affiliates Med	14600 Sherman Way Ste 300	VAN NUYS	CA	91405	818-781-7097
???	502 Torrance Blvd.	Redondo Beach	CA	90277	310-316-0811
???	1025 W OLYMPIC BLVD	LOS ANGELES	CA	90015	213-861-5950
???	2025 E ROUTE 66	GLENDORA	CA	91740	626-852-4977
1 World Urgent Care Center	925 S. Garfield Ave.	ALHAMBRA	CA	91801	626-300-8388
10TH STREET AFTER HOURS URGENT CARE	1450 10TH ST 200	SANTA MONICA	CA	90401	310-899-9793
Advance Care AAA Medical Group	1330 Fullerton Rd. Ste. 288	ROWLAND HEIGHTS	CA	91748	626-965-1233
ADVANCED URGENT CARE OF BEVERLY HILLS	242 S ROBERTSON BLVD	BEVERLY HILLS	CA	90211	310-652-2300
ADVANCED URGENT CARE OF PASADENA	797 S ARROYO PKWY	PASADENA	CA	91105	626-304-0404
AFTER HOURS MED GRP ON COLIMA INC	9200 COLIMA RD 101	WHITTIER	CA	90605	562-945-2128
After Hours Medical Group - La Habra	308 N. Harbor Blvd.	La Habra	CA	90631	562-266-3032
After Hours Pediatric	504 S. Sierra Madre Blvd.	Pasadena	CA	91107	626-795-8811
After Hours Pediatrics - Woodland Hills	20301 Ventura Blvd. Ste. 100	Woodland Hills	CA	91364	818-887-3710
AIRPORT URGENT CARE AND INDUSTRIAL MEDICINE	1117 W MANCHESTER BLVD K	INGLEWOOD	CA	90301	310-215-3555
ALL CARE MED GRP INC	2675 E SLAUSON AVE	HUNTINGTON PARK	CA	90255	323-589-6681
Anaheim Urgent Care - Culver City	9726 Venice Blvd.	CULVER CITY	CA	90232	310-202-1300
Anaheim Urgent Care - Venice	2006 Lincoln Blvd.	Venice	CA	90291	310-396-2273
AND Inc. Urgent Care	6426 Coldwater Canyon Ave.	North Hollywood	CA	91606	818-927-4112
AppleCare Immediate Care	11525 Brookshire Ave. #400	Downey	CA	90241	562-869-4497
Balboa Medical and Wellness Center	9900 Balboa Blvd. Ste A	Northridge	CA	91325	818-701-0017
BALDWIN HILLS CRENSHAW URGENT CARE	3650 M L KING JR BLVD 185	LOS ANGELES	CA	90008	323-294-4266
BEVERLY HILLS URGENT CARE INC	822 S ROBERTSON BLVD 350	LOS ANGELES	CA	90035	310-659-2555
BHCMG EXECUTIVE ER	8530 WILSHIRE BLVD 250	BEVERLY HILLS	CA	90211	310-657-0366
Bright Health Physicians Urgent Care Center	1850 S. Azusa Ave. Ste. 88	Hacienda Heights	CA	91745	626-225-4900

BRIGHT HLTH PHYSICIANS	15725 E WHITTIER BLVD UCC	WHITTIER	CA	90603	562-947-7754
BURBANK OCCUPATIONAL HLTH CTR	3413 W PACIFIC AVE 102	BURBANK	CA	91505	818-953-4408
CANOGA PARK URGENTCARE FAMILY MEDICINE	20905 SHERMAN WY	CANOGA PARK	CA	91303	818-564-4961
CASTAIC URGENT CARE INC	31905 CASTAIC RD 110	CASTAIC	CA	91384	661-294-0700
Clinica Medica de la Caridad	4347 E. Slauson Ave.	Maywood	CA	90270	323-773-3137
Comprehensive Care East Los Angeles Medical Group	6125 Whittier Blvd.	Los Angeles	CA	90022	323-887-0000
CONCENTRA URGENT CARE	6033 W CENTURY BLVD 200	LOS ANGELES	CA	90045	310-215-1600
CSMC Urgent Care Medical Group	8700 Beverly Blvd. Ste 1115	Los Angeles	CA	90048	310-423-8780
Cypress Urgent Care	6876 Katella Ave.	Cypress	CA	90630	714-903-8900
Doctors Express of Santa Clarita	19042 Solodad Canyon Rd.	Canyon Country	CA	91351	661-251-6300
Doctors On Demand	2143 S. Sepulveda B;vd. Ste 300	Los Angeles	CA	90025	310-445-0751
Dr. Paul's Immediate Care	1812 Artesia Blvd.	Redondo Beach	CA	90278	310-274-5600
El Monte Quality Care Medical Group	11026 Valley Mall	EL MONTE	CA	91731	626-443-4300
Emergency Specialist Physicians Medical Associates, Inc.	4101 Torrance Blvd.	Torrance	CA	90503	800-633-8745
ENCINO MED URGENT CARE	18055 VENTURA BLVD	ENCINO	CA	91316	818-881-8117
Encino Town Medical Group Treatment Center	17130 Ventura Blvd.	ENCINO	CA	91316	818-385-1300
Encino Urgent Care	18605 Ventura Blvd.	ENCINO	CA	91316	818-708-6163
Express Care/Mayflower Medical Group	1433 N. Hollenbeck Ave. Ste. 200	COVINA	CA	91722	626-331-2209
Fair Oaks Urgent Care Center	401 S. Fair Oaks Ave.	PASADENA	CA	91105	626-304-2696
FAMILY URGENT CAREAND INDUSTRIAL MED CLNC	412 W AVENUE J STE D	LANCASTER	CA	93534	661-723-3375
FCS MED CORP	5823 YORK BLVD 1	LOS ANGELES	CA	90042	323-255-1575
First Aid Urgent Care Inc.	7204 Foothill Blvd.	Tujunga	CA	91042	626-791-9004
Garrison Family Medical Group	41210 11TH ST W C	PALMDALE	CA	93551	661-947-7100
GARVEY HLTHY FAMILY MED CLINIC INC	705 E GARVEY AVE	MONTEREY PARK	CA	91755	626-312-5488
GLENDALE MEMORIAL OCCUPATIONAL MED GRP	222 W EULALIA ST 101	GLENDALE	CA	91204	818-246-4800
GLENOAKS URGENT CARE MED GRP INC	1100 W GLENOAKS BLVD	GLENDALE	CA	91202	818-242-3333
GREATER COVINA HLTHCARE CLINIC INC	605 E BADILLO ST 100/110/300	COVINA	CA	91723	626-732-9232
Greater Valley Urg Care	7301 Sepulveda Blvd., Suite 1	Van Nuys	CA	91405	818-782-7470
HealthFirst Medical Group	11817 Telegraph Rd.	Santa Fe Springs	CA	90670	562-949-9328
HealthFirst Medical Group	13440 Imperial Highway	Santa Fe Springs	CA	90670	562-926-3400
HOLLYWOOD URGENT CARE	5717 MELROSE AVE	LOS ANGELES	CA	90038	323-957-2273
HOLLYWOOD WALK IN CLINIC	6430 SELMA AVE	LOS ANGELES	CA	90028	323-848-4650
In His Image Family Clinic, Inc.	18251 Roscoe Blvd., Ste. #105	NORTHRIDGE	CA	91325	818-718-0500
KIUMARS ARFAI MD INC	19871 NORDHOFF ST	NORTHRIDGE	CA	91324	855-349-5050
LIU AND WANG MED CORP	1118 S GARFIELD AVE 201	ALHAMBRA	CA	91801	626-281-0090
LIU AND WANG MED CORP	18395 COLIMA RD	ROWLAND HEIGHTS	CA	91748	626-964-1120
Long Beach Urgent Care	2110 North Bellflower Blvd.	LONG BEACH	CA	90815	562-346-2222
M D MED CTR INC	600 N GARFIELD AVE 111	MONTEREY PARK	CA	91754	626-280-3651
MAGAN MED CLINIC INC	420 W ROWLAND ST	COVINA	CA	91723	626-331-6411
Marian Urgent Care	505 Plaza Dr.	Santa Maria	CA	93454	805-739-3863
Maywood Urgent Care	4316 E. Slauson Ave.	Maywood	CA	90270	323-773-2020
Med Center of Simi Valley	1980 Sequoia Ave.	Simi Valley	CA	93063	805-583-5555
MedPost Urgent Care	13299 E South St.	Cerritos	CA	90703	562-865-8750
MedPost Urgent Care	2010 E. Carson St.	LONG BEACH	CA	90807	562-424-5450
Memorial Urgent CA	450 E Spring St, Suite 9	Long Beach	CA	90806	310-933-0086
MEND URGENT CARE	4312 WOODMAN AVE 102	SHERMAN OAKS	CA	91423	818-646-2562
Mission Hospital, Huntington Park	3111 E Florence Ave	Huntington Park	CA	90255	323-582-8261
MOUNTAIN VIEW URGENT CARE GRP INC	255 E BONITA AVE	POMONA	CA	91767	909-434-1150
MVP Pediatric and Urgent Car PC	18555 Ventura Blvd. Ste. B	Tarzana	CA	91356	818-614-3088
NEW ANANDA MEDAND URGENT CARE INC	1648 TYLER AVE B	SOUTH EL MONTE	CA	91733	626-579-0103
NEW CARE CLINIC INC	8740 S SEPULVEDA BLVD 160	WESTCHESTER	CA	90045	310-645-2273
Newbury Park Urgent Care	2080 Newbury Rd. Ste. 8	Newbury Park	CA	91320	805-499-0308
North Hollywood Urgent Care	11126 Chandler Blvd.	North Hollywood	CA	91601	818-985-0044
Northridge Hosp Mc, Sherman Way Campus	14500 Sherman Circle	Van Nuys	CA	91405	818-997-0101
OCEAN FRONT URGENTCARE	31236 PALOS VERDES DR W	RNCH PALOS VER	CA	90275	310-544-2121
OCEAN MED FAMILY AND URGENT CARE MED CORP	1106 S PACIFIC CST HWY	REDONDO BEACH	CA	90277	310-316-1661
Ortho Urgent Care, Med Grp	2400 S Flower St.	Los Angeles	CA	90007	213-742-1013
ORTHOPAEDIC INS FOR CHILDREN	2501 S HOPE ST	LOS ANGELES	CA	90007	213-742-1000
Pacific Alliance Medical Center	531 W. College St.	Los Angeles	CA	90012	213-624-8411
Palisades Urgent Care	910 Via De La Paz Ste. 101	Pacific Palisades	CA	90272	310-454-4544
Palmdale Medical Group Inc.	44222 10th St. West	Lancaster	CA	93534	661-723-6800
PALOS VERDES FAMILY AND IMMEDIATE MED CARE	26516 CRENSHAW BLVD	PALOS VERDES PENIN	CA	90274	310-541-7911
PANAROMA URGENT CARE FM INC	14457 ROSCO BLVD	PANORAMA CITY	CA	91402	818-810-5947
Para Latino Medical Center	15955 Paramount Blvd.	Paramount	CA	90723	562-862-2775
Pasadena Community Urgent Care	133 N. Altadena Dr., 2nd Fl.	PASADENA	CA	91107	626-270-2400
Pasadena Community Urgent Care	3160 East Del Mar Blvd. Suite 110	PASADENA	CA	91107	626-270-2400
PEDIATRIC ACUTE CARE MED ASSOCS INC	5353 BALBOA BLVD 201	ENCINO	CA	91316	818-788-5437
Pediatric Management, Intensive Care	6430 Sunset Blvd., Suite 600	Los Angeles	CA	90028	213-669-2305
Pediatric Urgent Care in Santa Monica	1225 15th St. Ste. 2100	Santa Monica	CA	90404	310-825-0867
Playa Advance Urgent Care	5450 Lincoln Blvd.	PLAYA VISTA	CA	90094	310-305-9200
PLAYA VISTA MED CTR	6020 SEABLUFF DR 1	PLAYA VISTA	CA	90094	310-862-0400
Plaza Urgent Care	1500 W. West Covina Pkwy.	WEST COVINA	CA	91790	626-856-2248

ProActive Urgent Care Services	1230 W. 3rd St.	Los Angeles	CA	90017	213-977-9300
ProActive Urgent Care Services	132 S. Beaudry Dr.	Los Angeles	CA	90012	213-977-9300
Prohealth Medical Group Inc.	14860 Roscoe Blvd. Ste 200	PANORAMA CITY	CA	91402	818-933-4440
QUARTZ HILL WALK IN MED CTR	42357 50TH ST W 107	LANCASTER	CA	93536	661-943-6455
RAPID CARE URGENT CARE CTR	1130 W OLIVE AVE	BURBANK	CA	91506	818-843-8555
RAPID CARE URGENT CARE CTR	801 S CHEVY CHASE DR 105	GLENDALE	CA	91205	818-265-2200
RELIANT IMMEDIATE CARE MED	9601 S SEPULVEDA BLVD	LOS ANGELES	CA	90045	310-215-6020
Reliant Immediate Care Medical Group	2300 W. Beverly Blvd. Ste. 100	MONTEBELLO	CA	90640	626-467-0202
RESEDA URGENT CAREINC	6830 RESEDA BLVD	RESEDA	CA	91335	818-996-4888
San Miguel Urgent Care	2625 E. Florence St. #D	HUNTINGTON PARK	CA	90255	323-588-3800
SANTA MONICA URGENT CARE	524 COLORADO AVE	SANTA MONICA	CA	90401	310-394-2272
Seal Beach Urgent Care	1198 Pacific Coast Highway Ste 1	Seal Beach	CA	90740	562-598-2904
SHADI MED CORP	633 S LA BREA AVE	LOS ANGELES	CA	90036	323-938-9999
Silver Lake Medical Center	1711 W. Temple St. 2nd Fl.	Los Angeles	CA	90026	213-989-6100
Simi Health Center	1350 Los Angeles Ave.	Simi Valley	CA	93065	805-522-3782
Smartclinic Inc.	2707 E. Valley Blvd. Ste 116	West Covina	CA	91792	626-581-1000
SOUTHERN CALIFORNIA	5203 LAKEWOOD BLVD	LAKEWOOD	CA	90712	562-633-2273
STEPHAN T HONDA MDINC	2301 W EL SEGUNDO BLVD	HAWTHORNE	CA	90250	323-757-2118
STUDIO CITY URGENTCARE AND MED CTR INC	12660 RIVERSIDE DR 110	VALLEY VILLAGE	CA	91607	818-761-1800
SUMMIT URGENT CARE	38660 MEDICAL CTR DR A130	PALMDALE	CA	93551	661-273-7100
SUNSET URGENT CAREMED CTR INC	9201 W SUNSET BLVD 705	WEST HOLLYWOOD	CA	90069	310-271-2744
The Medical Group of Los Angeles	2208 W. 7th St.	Los Angeles	CA	90057	213-384-3434
Thousand Oaks Urgent Care	620 E. Janss Rd.	Thousand Oaks	CA	91360	805-495-6866
Torrance Family and Urgent Care, Inc.	2573 Pacific Coast Highway, Ste. B	Torrance	CA	90505	310-997-1796
Total Care Huntington Park Medical Group	6347 Pacific Blvd.	HUNTINGTON PARK	CA	90255	323-583-8383
United Urgent Care & Wellness Center	522 W. Carson St.	Carson	CA	90745	310-320-3400
Urgent Care America Medical Clinic	13470 Telegraph Rd.	WHITTIER	CA	90605	562-906-7766
Urgent Care Center of South Bay	4305 Torrance Blvd. Ste. 106	Torrance	CA	90503	310-542-9758
URGENT CARE PLUS INC	555 E OCEAN BLVD 110	LONG BEACH	CA	90802	562-285-5050
Urgent Nine Urgent Care	946 N. Brand Blvd.	Glendale	CA	91202	818-662-7000
Valencia Medical Care	27875 Smyth Dr. Ste 101	Valencia	CA	91355	661-702-1440
VALLEY URGENT CAREMED GRP	9346 CORBIN AVE	NORTHRIDGE	CA	91324	818-349-9966
VAN NUYS URGENT CARE FAMILY MEDICINE INC	7211 VAN NUYS BLVD	VAN NUYS	CA	91405	818-988-2722
VERDUGO HILLS URGENT CARE MED GRP INC	544 N GLENDALE AVE	GLENDALE	CA	91206	818-241-4331
Vermont Healthcare Center, Inc.	1234 Vermont Ave.	LOS ANGELES	CA	90029	323-660-5624
Vernon Urgent Care Center	231 W. Vernon Ave., Ste 112	LOS ANGELES	CA	90037	323-231-5181
VIP Urgent Care	18663 Ventura Blvd. Ste 200	Tarzana	CA	91356	818-881-9002
WEST COAST URGENT CARE CTRS	600 S LAKE AVE 105	PASADENA	CA	91106	626-844-8848
West LA Urgent Care	11600 Venice Blvd.	LOS ANGELES	CA	90066	310-390-9551
West Lake Urgent Care Adult + Pediatric Urgent Care	3180 Willow Lane Ste 114	Westlake Village	CA	91361	805-373-1785
WESTSIDE WALK IN CLINIC	3019 W WASHINGTON BLVD	MARINA DEL REY	CA	90292	310-305-1801
Willmington Urgent Care	714 N. Avalon Blvd.	Wilmington	CA	90744	310-522-4200
Willow Urgent Care	2704 E. Willow St.	Signal Hill	CA	90755	562-595-0203
Woodland Hills Medical Clinic Ventura	19825 Ventura Blvd.	Woodland Hills	CA	91364	818-340-3636
Zacoalco Urgent Care Center	7313 S. Compton Ave.	Los Angeles	CA	90001	323-923-0110

Community Clinics and Health Centers

For the most current list of Community Clinic and Health Center addresses, visit the CCALAC "Find a Clinic" page at http://ccalac.org/find-a-clinic.

Community Clinics and Health Centers in LA County are willing to accept referrals from EDs and Urgent Care Clinics for patients who do not have a PCP or Medical Home. Attached is a list of clinics by geography.

Community Clinics and Health Centers in LA County are willing to accept referrals from EDs and Urgent Care Clinics of patients who do not have a PCP or Medical Home. Below is a list of clinics by geography.

Fact Sheet: Community Clinics and Health Centers

LA's Community Clinics and Health Centers are proud to partner with local hospitals and emergency rooms to ensure that our residents can access quality health care services in the most appropriate setting. **The attached listing provides information on community clinics and health centers that may be available to receive patients more appropriately served in primary care.** For more information about LA's clinics, please go to www.ccalac.org.

What is a community clinic? A free clinic? A Community Health Center?

Community clinics, free clinics and community health centers (clinics) are all licensed and regulated by the State of California. Clinics may charge patients a fee based on the patient's income and ability to pay. These private non-profit organizations serve populations with limited access to health care, and are located in or serve a high need community (for example: low income populations, the uninsured, those with limited English proficiency, homeless persons).

What services do clinics provide?

All of the clinics on the attached listing offer primary health care, which means they provide non-emergency, outpatient medical services. Many clinics also have dental, mental health and pharmacy services. You'll also find x-ray, vision, obstetrics, specialty referral and other medical services at community clinics.

Who do clinics serve?

Clinics serve everyone, with a focus on providing services to the uninsured, under-insured, working poor, high-risk and vulnerable populations. Clinic services are developed to serve the unique needs of their communities, making clinics able to address cultural differences and economic disparities that can impact the health of their patients. Services available to patients may include:

- Trained medical interpreters and bilingual staff
- Transportation to and from appointments
- Mobile clinic to reach the homeless and other populations in some areas, and
- Evening/weekend hours for working families

How much does it cost to go to a clinic?

Community clinics serve all, regardless of ability to pay. Some clinics offer all services for free, while others use a "sliding fee scale" to determine the fee, meaning the patient is charged a fee based on the patient's income. Often, federal, state and local funders offset the cost of services provided to the uninsured. Clinics employ staff to facilitate enrollment into coverage for those who may be eligible for public programs. Clinics bill public health

coverage programs such as Medicare and Medi-Cal, as well as private insurers for services provided to covered patients.

Do you need to be a legal resident of the United States to use community clinics?
No; patients can receive services regardless of their residency status.

Medical Practice Action Team Roster

This section of the toolkit provides the Medical Practice Action Team roster.

PROVIDER / HEALTH PLAN ROSTER

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Safe Prescribing Medical Practice Action Team (MPAT) Roster

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