



## Call to Action

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

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

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

### Call to Action:

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

### Surgeon General: Turn the Tide

(<http://turnthetiderx.org/>)

### LETTER FROM THE SURGEON GENERAL

Dear Colleague,

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

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

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

have a bottle of pills. Yet the amount of pain reported by Americans has not changed. Now, nearly 2 million people in America have a prescription opioid use disorder, contributing to increased heroin use and the spread of HIV and hepatitis C.

I know solving this problem will not be easy. We often struggle to balance reducing our patients' pain with increasing their risk of opioid addiction. But, as clinicians, we have the unique power to help end this epidemic. As cynical as times may seem, the public still looks to our profession for hope during difficult moments. This is one of those times.

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

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

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

Thank you for your leadership.



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

**Centers for Disease Control (CDC)**

(<https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>)

[http://www.cdc.gov/drugoverdose/pdf/infographic-cdc\\_guideline\\_for\\_prescribing\\_opioids\\_for\\_chronic\\_pain-a.pdf](http://www.cdc.gov/drugoverdose/pdf/infographic-cdc_guideline_for_prescribing_opioids_for_chronic_pain-a.pdf)

CDC cares about the health, safety, and well-being of patients with chronic pain. CDC is committed to ensuring that these patients get the best possible care. There is not enough science to know whether opioids control chronic pain long term, but it is clear that they have very serious risks and side effects.

The amount of opioid prescriptions dispensed has **QUADRUPLED** since 1999



but the amount of pain that Americans report remains **UNCHANGED**

Since 1999, more than **165,000** PEOPLE HAVE DIED FROM OVERDOSE related to prescription opioids.



Nearly **2M** PEOPLE

either abused or were dependent on prescription opioids in 2014

#### WHY GUIDELINES FOR PRIMARY CARE PROVIDERS?

[http://www.cdc.gov/drugoverdose/pdf/guideline\\_infographic-a.pdf](http://www.cdc.gov/drugoverdose/pdf/guideline_infographic-a.pdf)

## WHY GUIDELINES FOR PRIMARY CARE PROVIDERS?

Primary care providers account for approximately

**50%**  
of prescription opioids dispensed



Nearly **2 million**

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

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

### MYTH

VS

### TRUTH

- 1 Opioids are effective long-term treatments for chronic pain
- 2 There is no unsafe dose of opioids as long as opioids are titrated slowly
- 3 The risk of addiction is minimal

While evidence supports short-term effectiveness of opioids, there is insufficient evidence that opioids control chronic pain effectively over the long term, and there is evidence that other treatments can be effective with less harm.

Daily opioid dosages close to or greater than 90 MME/day are associated with significant risks, and lower dosages are safer.

Up to one quarter of patients receiving prescription opioids long term in a primary care setting struggle with addiction. Certain risk factors increase susceptibility to opioid-associated harms: history of overdose, history of substance use disorder, higher opioid dosages, or concurrent benzodiazepine use.

## WHAT CAN PROVIDERS DO?



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

## PRACTICES AND ACTIONS



### USE NONOPIOID TREATMENT

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

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



### START LOW AND GO SLOW

When opioids are started, prescribe them at the lowest effective dose (Recommendation #2)

Studies show that high dosages (>300 MME/day) are associated with 2 to 3 times the risk of overdose compared to <30 MME/day.



### REVIEW PMP

Check prescription drug monitoring program data for high dosages and prescriptions from other providers (Recommendation #9)

A study showed patients with one or more risk factors (1 or more prescriptions, 4 or more prescriptions, or dosage >100 MME/day) accounted for 55% of all overdose deaths.



### AVOID CONCURRENT PRESCRIBING

Avoid prescribing opioids and benzodiazepines concurrently whenever possible (Recommendation #13)

One study found concurrent prescribing to be associated with a four-fold increase in risk for overdose that is compared with opioid prescription alone.



### OFFER TREATMENT FOR OPIOID USE DISORDER

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

A study showed patients prescribed high dosages of opioids long-term (>90 days) had 2.7 times the risk of opioid use disorder compared to patients not prescribed opioids.



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

LEARN MORE | [www.cdc.gov/drugoverdose/prescribing/guideline.html](http://www.cdc.gov/drugoverdose/prescribing/guideline.html)

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

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

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

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

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

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## MTV Documentary

MTV one hour special “[Prescription for Change: Ending America’s Opioid Crisis](#),” featuring President Obama and Grammy-award winning artist and recovery advocate Macklemore. (10/11/2016, 43 minutes)

<http://www.mtv.com/full-episodes/heir4r/prescription-for-change-prescription-for-change-ending-america-s-opioid-crisis-ep-1>

## Business Cases to Support Safe Opioid Prescribing Practices

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

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

### **Partnership Health Plan:**

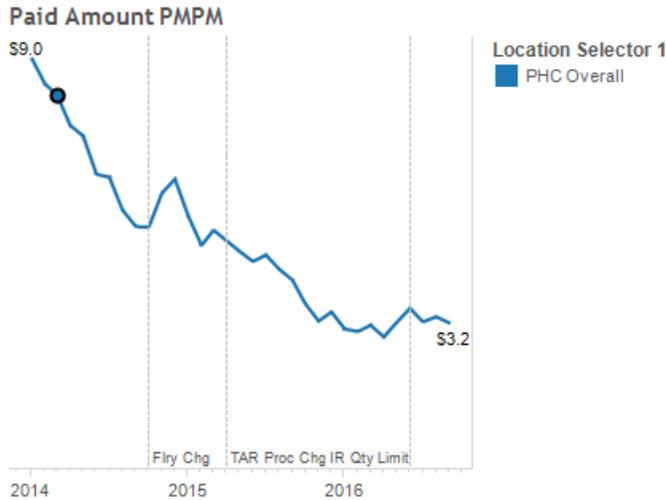
Partnership Health Plan data showed savings of almost \$1 million per month in decreased cost of opioid meds (<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CaseStudiesHealthPlansOpioid.pdf>).

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

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

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

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



The trend of Paid AmtP100MPM for Fill Dt Month. Color shows details about Location Selector 1. The data is filtered on Fill Dt (Months), which ranges from Jan 2014 to Sep 2016. The view is filtered on Location Selector 1, which keeps multiple members.

### **Blue Shield of California:**

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