Alameda County Safety Net Working Group on Opioid Prescribing

Community Standards for Opioid Prescribing

Brief description
A variety of factors (attention toward under treatment of pain, defunding of comprehensive pain clinics, and over-promotion of opioid medications) created an environment that now results in over 16,000 unintentional opioid overdose deaths per year in the US. The last several years has seen a growing push to address the opioid overdose epidemic through standardization of how we treat chronic pain. Examples of emerging standards include dose-ceilings (i.e. 100 morphine milligram equivalents), limits on co-prescribing opioid with other high risk medicine (benzodiazepines, carisoprodol, methadone, etc), co-prescribing naloxone for patients on chronic opioids, concomitant functional therapy (physical therapy, back class, etc) or mental health evaluations, and others.

In Portland, Oregon, after agreeing to follow certain evidence-based best practices, the number of patients who are chronic opioid users decreased by 50 percent within two years.

How does this improve care of patients living with chronic pain?
Standards create a consistent approach to chronic pain across a community and ensures patients receive appropriate treatment for their pain.

How does this decrease opioid misuse and overdose?
By drawing attention to best practices, standards can provide a benchmark for providers to prescribe safely.

Feasibility?
Moderate. Stakeholders would need to meet, review evidence, and agree on which standards to endorse.

Timeline?
Short. Other communities have laid the groundwork for adopting common standards.

Examples in other places

Location	Service
Oregon Pain Guidance	Dose-ceiling of 120 MMEs, among other standards
National Association of Medicaid Directors	Recommend a dose-ceiling of 120 MMEs for member organizations

Pro/Con

Consensus based process	Providers may perceive as overly intrusive
Consistency	Non-binding (compared with payer actions)
Standards drawn from the evidence-based	

Reference

- Oregon Pain Guidance. Available at: http://www.oregonpainguidance.org/
- Mercer. State Medicaid Interventions for preventing prescription drug abuse and overdose: a report for the National Association of Medicaid Directors. Phoenix, Arizona. October 2014.

Alameda County Safety Net Working Group on Opioid Prescribing

Data-Driven Process and Decision Making

Brief description
While prescription opioid abuse has reached epidemic proportions over the past two decades, there is marked geographic variation in morbidity and mortality of opioid misuse, both nationwide and within California. Available public health data in Alameda County paints a limited picture of what, from interviews with providers, is a significant and growing problem.

How does this improve care of patients living with chronic pain?
Ideally, improved data will permit interventions to reach those most likely to benefit from them. For instances, a clinic with overall low per capita morphine milligram equivalents (a standard measure of opioid dose) could be studied to understand how they achieved this outcome.

How does this decrease opioid misuse and overdose?
Data could inform targeted community outreach, for instance increasing overdose education and naloxone distribution in a neighborhood with a high rate of overdoses.

Between 2006 and 2011, the overall number of deaths from opioids in Alameda County remained stable (mean 35 per year), while the number of ER visits more than doubled (from 78 to 172).

Feasibility?
Moderate. Requires buy-in of stakeholders to meet and agree to goals.

Timeline?
Medium. Would require a series of meetings develop process and goals, followed by implementation.

Examples in other places

Location	Service
Marin County	RxSafe Marin initiative formed a data working group based off blueprint from NYC program, RxStat
CalOptima (Medi-Cal plan of Orange County)	Runs data reports to identify potential fraud and meets with State officials monthly to ensure cases have been resolved

Pro/Con

Target limited resource to maximize impact	High upfront investment of time/resources
Data-driven process inherently appealing to providers and policy makers	Concerns about quality of data cast doubt over decisions driven from data (“data skeptics”)

Reference

- Alameda County Public Health data. Available upon request.
- RxSafe Marin. 2013. Available at: http://www.rxsafemarin.org/action-team--data.html
- Heller D. RxStat: Technical Assistance Manual. 2014. Available at: http://www.pdmpassist.org/pdf/RxStat%203.pdf

Alameda County Safety Net Working Group on Opioid Prescribing

Safe Pain Medicine Prescribing Recommendations for Emergency Rooms (and Urgent Care Clinics)

Brief description
Experts agree chronic pain is best managed in the ambulatory setting yet emergency rooms are the single largest ambulatory source of new prescriptions and refills of opioids. Developed by the California State chapter of the American College of Emergency Physicians, the Safe Pain Medicine Prescribing recommendations are consistent with emerging practices and have already adopted in several other California counties, including San Diego and Los Angeles Counties.

How does this improve care of patients living with chronic pain?
Chronic pain is a problem best managed in primary care clinics, where patients benefit from longitudinal care by a provider who knows them well. Additionally, clinics are better equipped to connect patients with additional services known to benefit patients suffering chronic pain, such as behavioral health and physical therapy.

How does this decrease opioid misuse and overdose?
Decreases incentive for patients seeking opioids in to ERs and urgent cares.

Feasibility and timeline?
Easy and short ("low-hanging fruit")

From 2006 to 2011 Alameda County experienced an over two-fold increase in ER visits for opioid abuse and overdose.

Examples in other places

Location	Service
San Diego County	Took leadership role in developing CA ACEP guidelines
Washington State	Statewide, evidence guided guidelines

Pro/Con

Reinforces principles of chronic pain treatment ("philosophically aligned")	Difficult to enforce
Ready for implementation	Unproven intervention (expert opinion)

Reference

- NCHS CDC. Vital and Health Statistics, Series 13, number 163, December, 2006. Available at: http://www.cdc.gov/nchs/data/series/sr_13/sr13_163.pdf#page=26#page=26
- Alameda County Public Health data. Available upon request.
- Safe Prescribing. California ACEP. Available at: http://californiaacep.org/public-health/safe-prescribing/
- San Diego Safe Prescribing. Available at: http://www.sandiegosafeprescribing.org/
- WA State ER guidelines. Washington ACEP. Available at: http://washingtonacep.org/Postings/edopioidabuseguidelinesfinal.pdf

Alameda County Safety Net Working Group on Opioid Prescribing

Clinical Guidelines for Managing Chronic Pain

Brief description
Clinical guidelines standardize the care patients living with chronic pain receive in a clinic, clarifying expectations -- for instance, improved *function* and *quality of life*, in addition to reduced pain score -- and establishing concrete exit strategies. Moreover, guidelines can delineate a holistic approach to treatment of chronic pain in which opioids are but one tool among many.

How does this improve care of patients living with chronic pain?
A standardized approach helps remove perception of stigmatization of certain patients.

How does this decrease opioid misuse and overdose?
Guidelines help providers screen for established risk factors for misuse and overdose.

In Washington State, the majority of surveyed physicians found statewide guidelines helpful and a threshold of 120 mg/d MME dose reasonable or too high.

Feasibility?
Easy, many clinics in Alameda County have already created their own guidelines.

Timeline?
Short, guidelines (Medical Board of California or homegrown) already exist.

Examples in other places

Location	Service
CHCN clinics (i.e. La Clinica, LifeLong, etc.)	Developed homegrown guidelines
Medical Board of California	Developed guidelines for management of opioids
Washington State government	Developed guidelines for management of opioids

Pro/Con

Systematized approach can improve workflow and may improve outcomes (poor evidence for this)	Patients may perceive requirements as overly punitive
Helps identify high-risk patients	Difficult to enforce
Emphasis on non-opioid pain modalities	Added workflow may meet resistance at first

Reference

- Morse JS. J Opioid Manag. 2011;7(6):427-33.
- MBC. Guidelines for prescribing controlled substances for pain. Nov 2014. Available at: http://www.mbc.ca.gov/licensees/prescribing/pain_guidelines.pdf
- Agency Medical Director's Group. Opioid dosing guideline for chronic non-cancer pain. Washington. Available at: http://www.agencymeddirectors.wa.gov/opioiddosing.asp

Alameda County Safety Net Working Group on Opioid Prescribing

Bolstering Non-Opioid Modalities for Chronic Pain

Brief description
Chronic pain is a biopsychosocial phenomenon best treated by targeting all three domains. Beyond medications (opioids, NSAIDs, antidepressants, etc), a "whole person" approach to chronic pain includes functional therapies (exercise, PT, OT, etc), behavioral health (CBT, support groups, etc), alternative medicine (acupuncture, Tai Chi, etc), and interventional procedures (nerve blocks, joint injections, etc). Indeed, certain modalities are more promising than opioids.

How does this improve care of patients living with chronic pain?
Opioids for chronic non-cancer pain are moderately effective at best. Experience from clinics addressing the multifaceted dimensions of pain report improvement in patient experiences and outcomes.

Reduction in numeric pain rating scale:

-Physical fitness: 30-60%
-CBT/Mindfulness: 30-50%
-Sleep restoration: 30-40%
-Opioids: <30%
-Tricyclics: <30%
-Antiepileptics: <30%
-Acupuncture: >10+%

How does this decrease opioid misuse and overdose?
Non-opioid modalities in theory create space to reduce total opioid burden.

Feasibility?
Challenging. Requires pooling existing knowledge of local resources and investment of new resources into these treatments.

Timeline?
Medium to long-term. Viewed as a necessary strategy to reduce community burden of opioid misuse so sooner we begin the better.

Examples in other places

Location	Service
La Clínica de la Raza, Alameda County	Behavioral health evaluation are performed on all patients being started on chronic opioid therapy.
Central City Concern, Portland Oregon	A Portland clinic that serves homeless persons developed a rich set of non-opioid treatment options for patients, including drop-in acupuncture, movement classes and occupational therapy

Pro/Con

Patient-centered	Resource intensive

Reference

- Personal communication with Jim Shames, MD. Jackson County, Oregon.
- La Clínica de la Raza. Chronic pain program. Oakland, California. February 2014.

Solotaroff R. Recovery based pain management at Central City Concern. April 2014. Available at: http://transformationcenter.org/wp-content/uploads/2014/05/Solotaroff-presentation.pptx

Alameda County Safety Net Working Group on Opioid Prescribing

Healthcare Payer Actions

Brief description
Through payment incentives and utilization controls, healthcare payers can guide providers toward best practices. With respect to opioid therapy, actions might include a dose-ceiling (i.e. 100 MME), limits on co-prescribing opioids with other high-risk medicines (benzodiazepines, carisoprodol, methadone, etc.), concomitant functional therapy (physical therapy, back class, etc) or mental health evaluations, "lock-in" programs (case-by-case determination for high-risk patients that opioids will only be covered when prescribed by single physician at single pharmacy) and others.

How does this improve care of patients living with chronic pain?
Payer actions help providers practice according to most up-to-date practices.

How does this decrease opioid misuse and overdose?
Payer action can serve to decrease the most risky prescribing behaviors, for instance co-prescribing benzodiazepines with opioids.

Since implementing a series of payer actions, Partnership HealthPlan of California, a Medi-Cal administrator serving many Northern California counties, has seen a 40-percent drop in use of long-acting opioid medications among its members.

Feasibility?
Difficult, predominantly because of anticipated push-back from providers. Agreement on which actions may also be challenge.

Timeline?
Medium to long-term

Examples in other places

Location	Service
Partnership HealthPlan of California	Implemented several interventions, including a payment incentive for providers to become buprenorphine prescribers (X-DEA certified) and a dose-ceiling of 120 MMEs.
Synovation Medical Group, Southern California	Implemented a payment structure where at least one-third of the payment is dependent on improvement of the patient's functional status

Pro/Con

Enforceable	Provider resentment (perceived as too intrusive?)
Actions can be supported by evidence base	Disagreement on particular actions to adopt
	Medicaid regulations that impede integrated care solutions

Reference

- Partnership HealthPlan of California. Managing pain safely. Available at: http://www.partnershiphp.org/Providers/HealthServices/Pages/Managing-Pain-Safely.aspx
- Cristobal K. Striking a balance: safety-net leaders explore solutions to the prescription painkiller epidemic. March 2015.

Alameda County Safety Net Working Group on Opioid Prescribing

Enhance Public Action on Opioid Misuse

Brief description
As overdose deaths have reached epidemic proportions -- quadrupling since the nineties -- messaging needs to better communicate the risks of these medicines to patients and the public. Strategies include general public messaging, school-based interventions, and targeting higher risk populations (for instance, co-prescribing naloxone). Additionally, improving and publicizing Alameda County's existing drug take-back program is another strategy.

How does this improve care of patients living with chronic pain?
Enhancing patients' self-efficacy in managing their chronic pain, through improved knowledge benefits of opioids (and other treatments for chronic pain).

Over 70 percent of persons who misuse opioids got them from a friend or relative. Only 1 in 5 consider prescription pain drugs to be a serious safety threat.

How does this decrease opioid misuse and overdose?
Naloxone is an evidence-based intervention to decrease overdose death. Improving safe storage and disposal of opioids would reduce inadvertent diversion. Effectively communicating risks inherent to opioids (dependence, addiction, and death), may reduce patient demand for them.

Feasibility?
Easy, general agreement among stakeholders about need for improved patient/public awareness.

Timeline?
Medium, depending on time to pick specific actions and develop appropriate materials.

Examples in other places

Location	Service
Alameda County drug take-back program	Prescription opioids can be returned to pre-specified law enforcement sites
San Francisco Dept. of Public Health	Naloxone distribution for high-risk patients, including IVDU (The DOPE Project) and in clinics
Staten Island, New York City	Implemented public awareness campaign as part of multi-pronged initiative on opioid misuse

Pro/Con

Patient-centered	Resource intensive
Evidence-based (naloxone)	Poor evidence (take-back, patient education)

Reference

- Chen LH, et al. MMWR. 2015;64:32.
- Jones CM, et al. JAMA Intern Med. 2014;174(5):802-3.
- National Safety Council. What Americans believe about opioid prescription painkiller use. Available at: http://www.nsc.org/NewsDocuments/031115-Public-Opinion-Poll.pdf
- Alameda County Safe Drug Disposal website: http://www.acgov.org/aceh/safedisposal/
- The DOPE Project: http://harmreduction.org/our-work/overdose-prevention/bay-area-dope/
- Frazier I. The Antidote. The New Yorker. September 8, 2014.