Alameda County Safety Net Working Group on Opioid Prescribing
Consensus Matrix Results

Horizontal stacked bar chart showing consensus results (Agree / Needs more discussion / Disagree) for the following items, from top to bottom:

- UTox part of chronic opioid mgmt.
- Reduce doctor shopping through consistent use of CURES and urine screening.
- Reduce inappropriate new starts of chronic opioids in low-evidence situation.
- More consistent patient education.
- Education for providers (and patients!) on: Physical risks; needed lab and EKG monitoring.
- Educate pts taking opioids: Meds in the home are a risk for family, so keep them securely.
- Educate the public: Unused pills in medicine cabinets and closets are major source of opioids in community.
- Implement peer evaluation and advice process (by a Dr. who is judicious and a good communicator).
- Educate patients, providers, and public on alternative/complementary modalities.
- List of accessible modalities should be broad and customized for patient geography and cultures.
- Educate pts taking opioids: It's important to take opioids responsibly.
- A multi-disciplinary team organized and available to support patients weaning off opioids.
- Educate the public: How to appropriately dispose of narcotics.
- Educate the public: Statistics on death and overdose.
- Educate the public: Effectiveness of opiates (short- and long-term).
- Embed a medication dose calculator in the EHR for decision support.
- Reduce co-prescribing of benzos.
- Reduce number of patients on high-dose methadone and other long-acting meds.
- Educate pts: Side effects more dangerous with age and as you add meds.
- Use motivational interviewing to identify patient goals, with emphasis on intervention.
- Population-based reviews for high-dose methadone or co-prescribed pts; check EHR for criteria.
- Educate the public: Availability and importance of lock boxes.
- Naloxone should be routinely prescribed for people on high dose opioids.
- CURES should be checked on every patient in the practice as part of intake.
- All primary care clinics should offer pain mgmt groups and CBT as a routine part of treatment.
- Adopt morphine equivalent limit of 120 mg.
- Attempting CBT or a pain group should be a requirement for anyone on chronic opioids.
- Pursue/ask for health plan controls on prescribing limits.
- All chronic pain patients on opioids should be evaluated by behavioral health.
- Encourage patients on long-acting opioids (methadone or OxyContin) to switch to bupe.

Legend: Agree (blue), Needs more discussion (red), Disagree (green)

X-axis: 0%, 20%, 40%, 60%, 80%, 100%