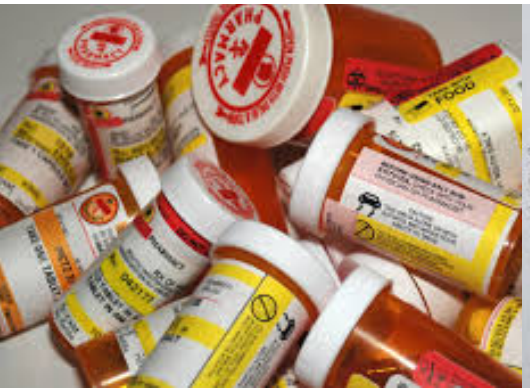
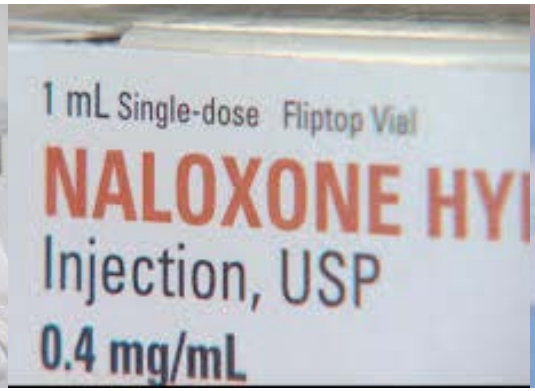
Opioid Working Group Reconvening

Welcome!

Please find your name tag; seats are assigned to keep the discussion lively.

Alameda County Health Care Services Agency
Administration & Indigent Health





Reconvening

Kathleen Clanon, MD	December 15, 2015	Alameda County Safety Net Working Group on Opioid Prescribing

Goals for Today

- Review the work of the 4 small working groups
- Identify the recommendations that we want to move forward with
- Reorganize into 3 implementation groups for the next 6-month phase of work
- Get input on tools
- Have fun

Introductions

1. Introduce yourself to other people at your table
2. Coalition staff introductions
3. Model for collaboration: Marshmallow Challenge
4. Supervisor Miley Welcome: Video
5. Family and patient impact story

Working Group Focus Areas

Working Group 1
Enhancing Public Knowledge of Opioid Dangers and Misuse

Working Group 2
Implementing Clinical Guidelines for Managing Chronic Pain

Working Group 3
Bolstering Non-Opioid Treatments for Chronic Pain

Working Group 4
Management of Opioid-dependent Patients

Working Group (WG) Participants

WG1 – Enhancing Public Knowledge of Opioid Dangers and Misuse

Aglaia Panos
Barry Shibuya
Brendan Kober
Cheryl Baggeroer
Kathleen Clanon
Loris Mattox
Maia White
Nora Branning
Pam Gumbs
Patricia Calloway
Sheilani Alix
Stacee Brackens
Tryvon Lynch
Veronica King

WG2 – Implementing Clinical Guidelines for Managing Chronic Pain

Ajitha Nair
Amy Smith
Anna Steiner
Daveena Ma
Holvis Delgadillo
Jean Marsters
Kathleen Clanon
Kelly Knight
Larry Boly
Nora Branning
Sarah Carrillo
Sheilani Alix
Veronica Ramirez

Working Group (WG) Participants

WG3 – Bolstering Non-Opioid Treatments for Chronic Pain

Aaron Chapman
Aglaia Panos
Amy Smith
Carole Tillman
Damon Francis
Jeffery Seal
Kathleen Clanon
Larry Boly
Loris Mattox
Nancy Facher
Patricia Calloway
Saleena Gupte
Sarah Carillo
Sharone Abramowitz
Stan Adamson
Steven Chen

WG4 – Management of Opioid Dependent Patients

Christina Kim
David Moskowitz
Gilbert Blacksmith
Holvis Delgadillo
Jean Marsters
Kathleen Clanon
Kelly Knight
Laura Miller
Lily Boris
Maria Magat
Marielle Nelson
Sophy Wong
Tryvon Lynch
Veronica King

What We Talked About

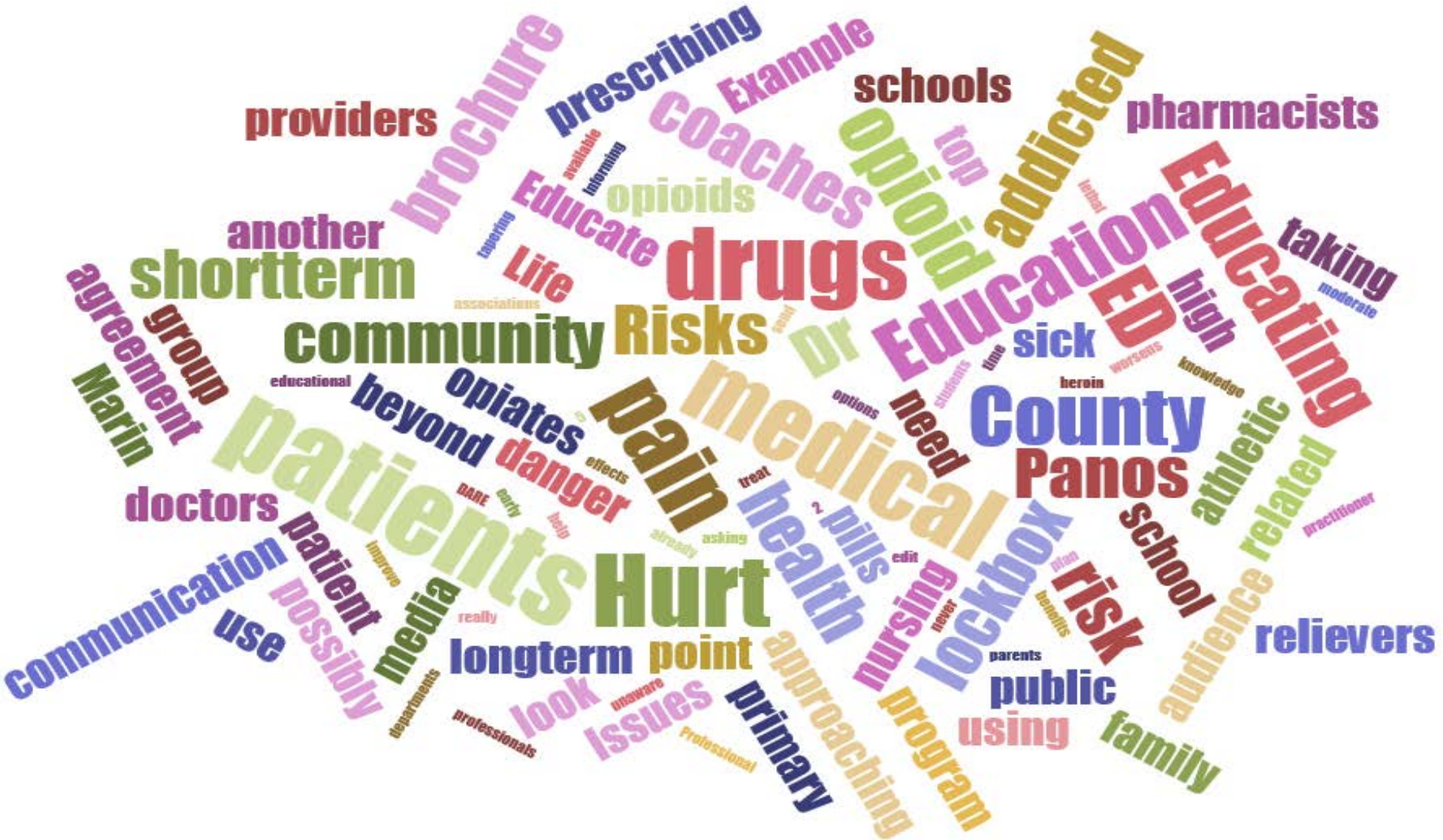
Group 1

Group 3

Group 2

Group 4

Working Group 1 – Enhancing Public Knowledge



WG1- Enhancing Public Knowledge of Opioid Misuse
Working Group Charge

- Decide which messages are important to go to general public.
- Which messages are important for people taking opioids and their families.
- What form of public education should we invest in?
- Who should the key audiences be?

WG1- Enhancing Public Knowledge of Opioid Misuse

What Does Success Look Like?

- Increased awareness of the opioid overdose epidemic
- Overall decrease in number of pills prescribed
- Get Patients/families asking, "Are your pain pills making you sick?"
- Patients come in knowing about the risk; already asking about other options
- Increase in appropriate storage & disposal of unused opioids

WG1- Enhancing Public Knowledge of Opioid Misuse

What Success Looks Like

Audiences:

- Doctors and other health care staff
- Nurses, especially home visiting nurses
- Dentists and other prescribers
- Families: Risks and the need to lock up meds
- Athletic coaches
- Kids

WG1- Enhancing Public Knowledge of Opioid Misuse

What We Agreed On

What the public needs to know:

- Statistics on death and overdose
- Availability and importance of lock boxes
- Unused pills in medicine cabinets and closets are major source of opioids in community
- How to appropriately dispose of narcotics

ALAMEDA COUNTY MEDICATION DISPOSAL INITIATIVE

WG1- Enhancing Public Knowledge of Opioid Misuse
What We Agreed On

What people taking opioids need to know:

- Effectiveness of opiates (short- and long-term)
- Side effects may become more dangerous as you age (adverse effects on bone density, sleep, constipation, heart, testosterone, etc.)
  and as you add meds (benzos, alcohol, etc.)
- It's important to take opioids responsibly
- Meds in the home are a risk for family, so keep them securely

WG1- Enhancing Public Knowledge of Opioid Misuse

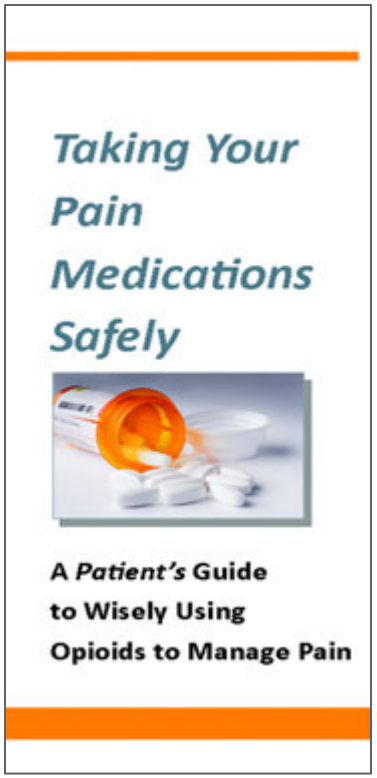
What We Discussed/Have not Agreed on:

- What are the best methods for disseminating information about opioids to the public and patients?
- Youth: At what age should we be working with them?

WG1- Enhancing Public Knowledge of Opioid Misuse

Working Group Product

Pamphlet: *Taking Your Pain Medications Safely*



WG2 - Implementing Clinical Guidelines for Managing Chronic Pain

WG2 - Implementing Clinical Guidelines for Managing Chronic Pain

Working Group Charge

- Streamline guidelines from adoption to implementation
- Prioritize the high-impact parts of the guidelines for extra emphasis
- Support consistency of clinical processes within and between clinics/practices

What Success Looks Like

- Patients with chronic pain are safer and have good function
- For common problems, doctors know what **not** to prescribe and what options are for pain
- Consistency among prescribing standards through guidelines
- Guidelines specifically for people now on opioids for chronic pain management:
  - Guidelines on importance of consistent use of controlled measured use agreements (CMUAs) and uTox (need a written policy)
  - Tool for difficult conversations and for consistency in communication

WG2 - Implementing Clinical Guidelines for Managing Chronic Pain

What We Agreed On

Highest Priority for Implementation:

- Reduce co-prescribing of benzos
- Reduce number of patients on high-dose methadone and other long-acting meds
- Reduce inappropriate new starts of chronic opioids in low-evidence situations
- More consistent patient education
- Reduce doctor shopping through consistent use of CURES and urine screening

CURES 2.0

WG2 - Implementing Clinical Guidelines for Managing Chronic Pain

What We Discussed/Have not Agreed on:

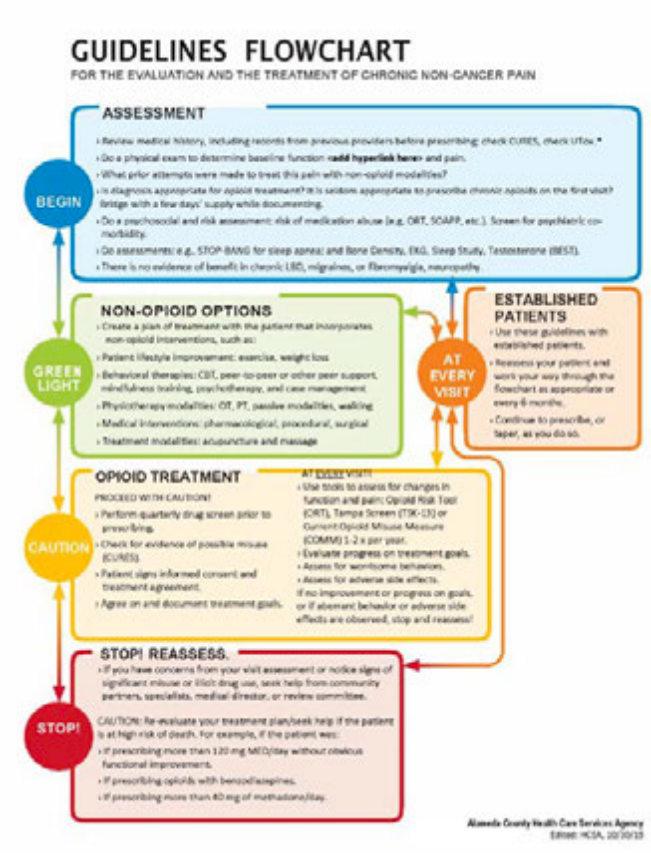
- Morphine equivalent dosing limit as a benchmark
- What to do with uTox results
- Whether all chronic pain patients

  should be co-managed with behavioral health

WG2 - Implementing Clinical Guidelines for Managing Chronic Pain

Work Group Product

Guidelines Flowchart (with WG 4)



Consensus Matrix

- Find a blank matrix on your table.
- For each of the recommendations for WG1 and 2, circle ONE answer:
  - Agree (✓)
  - Oppose (✗)
  - Needs more discussion
- When you finish, spend 5 minutes discussing answers at your table.
- Keep your matrix until the WG3 and 4 presentations are completed. We will collect and tabulate the answers then.

CONSENSUS MATRIX

1. For each of the recommendations for WG1 and 2, circle ONE answer.

WG1- Enhancing Public Knowledge of Opioid Misuse

What We Agreed On

What the public needs to know: Statistics on death and overdose	✗	✓	Needs more discussion
What the public needs to know: Availability and importance of lock boxes	✗	✓	Needs more discussion
What the public needs to know: Unused pills in medicine cabinets and closets are major source of opioids in community	✗	✓	Needs more discussion
What the public needs to know: How to appropriately dispose of narcotics	✗	✓	Needs more discussion
What people taking opioids need to know: Effectiveness of opiates (short- and long-term)	✗	✓	Needs more discussion
What people taking opioids need to know: Side effects may become more dangerous as you age (adverse effects on bone density, sleep, constipation, heart, testosterone, etc.) and as you add meds (benzos, alcohol, etc.)	✗	✓	Needs more discussion
What people taking opioids need to know: It's important to take opioids responsibly	✗	✓	Needs more discussion
What people taking opioids need to know: Meds in the home are a risk for family, so keep them securely	✗	✓	Needs more discussion

WG2 - Implementing Clinical Guidelines for Managing Chronic Pain

What We Agreed On

Highest priority for implementation: Reduce co-prescribing of benzos	✗	✓	Needs more discussion
Highest priority for implementation: Reduce number of patients on high-dose methadone and other long-acting meds	✗	✓	Needs more discussion
Highest priority for implementation: More consistent patient education	✗	✓	Needs more discussion
Highest priority for implementation: Reduce inappropriate new starts of chronic opioids in low evidence situations	✗	✓	Needs more discussion
Highest priority for implementation: Reduce doctor shopping through consistent use of CURES and urine screening	✗	✓	Needs more discussion

What We Discussed/Have Not Agreed On

We will adopt a morphine equivalent dosing limit of 120 mmgs as a benchmark. Patients over that limit should be flagged for additional education and weaning.	✗	✓	Needs more discussion
UTox should be a part of chronic opioid management, and there should be a consistent protocol as to how the results are used.	✗	✓	Needs more discussion
All chronic pain patients on opioids should be evaluated by behavioral health.	✗	✓	Needs more discussion

Break!!

WG3 - Bolstering Non-Opioid Treatments for Chronic Pain

WG3 - Bolstering Non-Opioid Treatments for Chronic Pain
Working Group Charge

- Keep the patient at the center
- Build a sustainable resource list
- Identify gaps in pain management resources
- Identify ways to advocate for more resources

WG3 - Bolstering Non-Opioid Treatments for Chronic Pain
What Success Looks Like

- All our clinics use a model that includes groups, manual medicine, CBT, and acupuncture
- Complementary/alternative treatments (yoga, massage, etc.) are easily available
- An "ICU of Pain" (a more robust, county level program for help with harder patients) also exists and is available for patients who need it
- The array of therapies mirrors the diverse communities; we work in

WG3 - Bolstering Non-Opioid Treatments for Chronic Pain
What Success Looks Like (continued)

Group 3 was VERY Patient-Centered:

- Offering patients a continuum that includes self-management so they are empowered
- Allowing patients to have options; different models
- Supporting self-care
- Developing training tools; not one size fits all
- Allowing patient to self-accept
- Learning what the patient's goals are!!! Use motivational interviewing
- Allowing patients to come in groups; use bio-pyscho-social-spiritual model to support purpose, belonging, and self-acceptance
- Including substantial behavioral health piece; address past trauma
- A lot more education for patients, providers, and public on:
  - What is pain (acute vs. chronic) and available alternatives to pills
  - Preventative care in the community; developing resiliency
  - Multiple populations/issues; how to address an individual presenting with pain

WG3 - Bolstering Non-Opioid Treatments for Chronic Pain
What We Agreed On

Recommendations:

- More education on alternative/complementary modalities for patients, providers, and public
- Use motivational interviewing to identify patient goals, with emphasis on intervention
- List of accessible modalities should be broad and customized for patient geography and cultures

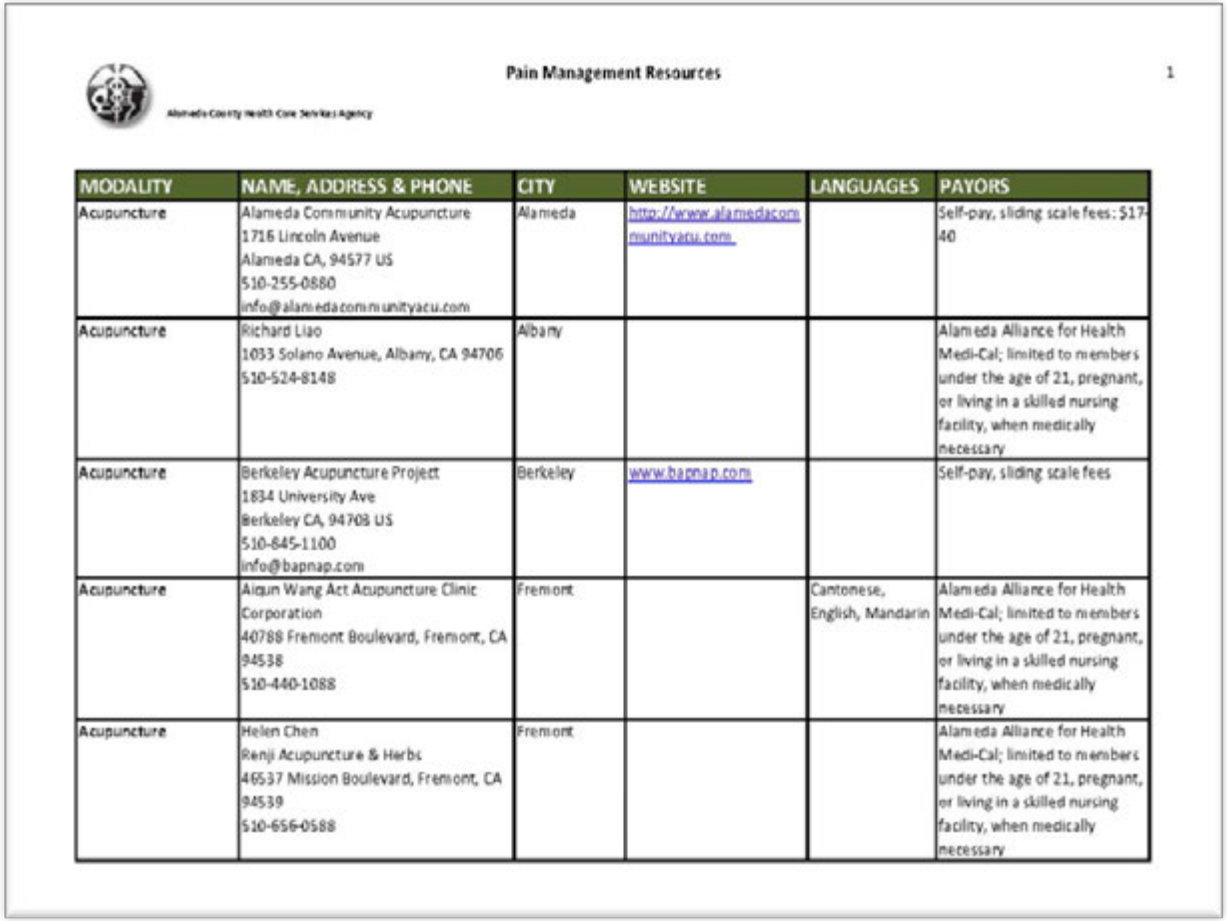
WG3 - Bolstering Non-Opioid Treatments for Chronic Pain

What We Discussed/Have not Agreed on:

- Should attempting CBT or pain group be a requirement for anyone on chronic opioids?
- Should all clinics offer pain management groups and CBT as a routine part of treatment?
- What is the best way to update and disseminate the list of alternative and complementary treatments?

WG3 - Setting Community Standards
Work Group Product

Resource list of alternative/complementary modalities



Pain Management Resources 1

Alameda County Health Care Services Agency

MODALITY	NAME, ADDRESS & PHONE	CITY	WEBSITE	LANGUAGES	PAYORS
Acupuncture	Alameda Community Acupuncture 1716 Lincoln Avenue Alameda CA, 94577 US 510-255-0880 info@alamedacommunityacu.com	Alameda	http://www.alamedacommunityacu.com		Self-pay, sliding scale fees: $17-40
Acupuncture	Richard Liao 1033 Solano Avenue, Albany, CA 94706 510-524-8148	Albany			Alameda Alliance for Health Medi-Cal; limited to members under the age of 21, pregnant, or living in a skilled nursing facility, when medically necessary
Acupuncture	Berkeley Acupuncture Project 1834 University Ave Berkeley CA, 94708 US 510-845-1100 info@bapnap.com	Berkeley	www.bapnap.com		Self-pay, sliding scale fees
Acupuncture	Aiqun Wang Act Acupuncture Clinic Corporation 40788 Fremont Boulevard, Fremont, CA 94538 510-440-1088	Fremont		Cantonese, English, Mandarin	Alameda Alliance for Health Medi-Cal; limited to members under the age of 21, pregnant, or living in a skilled nursing facility, when medically necessary
Acupuncture	Helen Chen Renji Acupuncture & Herbs 46537 Mission Boulevard, Fremont, CA 94539 510-656-0588	Fremont			Alameda Alliance for Health Medi-Cal; limited to members under the age of 21, pregnant, or living in a skilled nursing facility, when medically necessary

Working Group 4
Management of Opioid Dependent Patients

WG4 - Management of Opioid Dependent Patients
Working Group Charge

- Help identify resources needed for best care of this group
- How should weaning/dose reduction be handled in clinics?

- What are the critical elements of monitoring for people on chronic opioids?
- Explore buprenorphine in primary and emergency care

WG4 - Management of Opioid Dependent Patients

What Success Looks Like

- Feedback from patients says they are getting good treatment
- Tapering protocols are available and in use in every clinic
- Standard dose agreements are being followed
- Buprenorphine is available in primary and emergency care

Improved safety when opioids are prescribed:

- Clinicians and other staff check CURES regularly
- Reduced methadone dosages; switch to short-acting
- More risk stratification: Services/care plan designed that recognize who is at high risk for overdose or for addiction

WG4 - Management of Opioid Dependent Patients
What Success Looks Like (continued)

Improved safety when opioids are prescribed:

- Routine communication among members of the patient's care team, including clinic, hospital, and jail. Share information. Currently, narcotic treatment programs (NTPs) are siloed from primary care, where pain meds are received.
- Put in place for people with pain:
  - Integrated programs for serious mental illness, substance abuse, and pain mgmt.
  - More slots open/available for:
    - Referral for 2nd opinions (from pain clinic providers, peers at medical homes)
    - Addiction treatment

WG4 - Management of Opioid Dependent Patients

What We Agreed On

Recommendations:

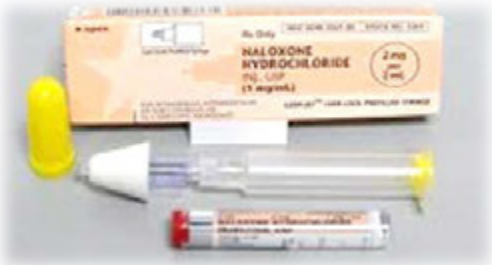
- Conduct population-based reviews looking for high-dose methadone patients, co-prescribed pts; check EHR for criteria
- Implement peer evaluation and advice process. Must be provided consistently by a physician who is recognized as judicious and a good communicator. The patient may or may not be present
- Embed a medication dose calculator in the EHR for decision support
- Education for providers (and patients!) on: Physical risks of chronic opioid use; needed lab and EKG monitoring for patients on chronic opioids
- A multi-disciplinary team organized and available to support patients weaning off opioids

WG4 - Management of Opioid Dependent Patients

What We Discussed/Have not Agreed on:

- Should CURES be checked on every patient in the practice as part of intake?
- Should prior auths be used as a tool for external control of higher dose prescribing?
- Which chronic opioid patients should switch to buprenorphine?

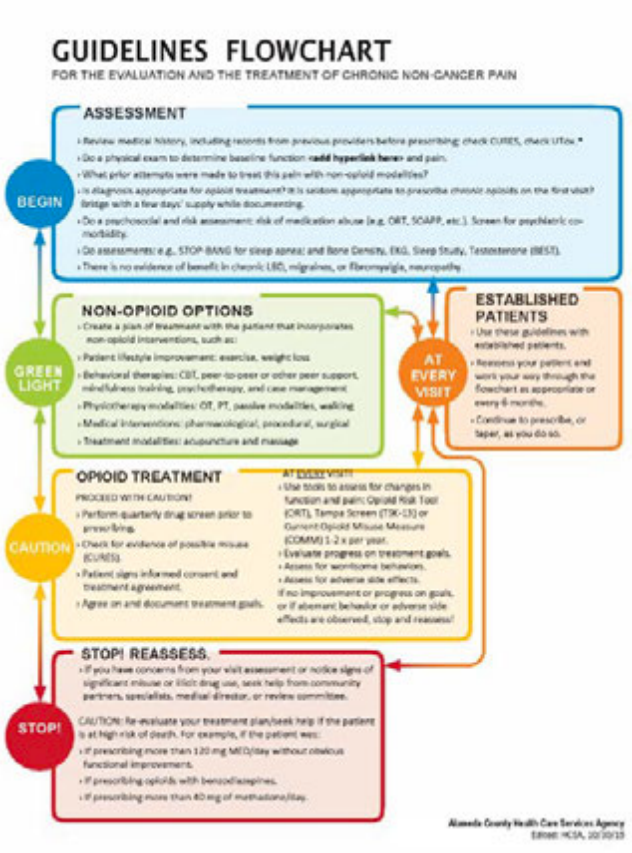
- Should Naloxone be routinely prescribed for people on high dose (or any dose) opioids; or only if overdose risk?



WG4 - Management of Opioid Dependent Patients

Work Group Product

Guidelines Flowchart



Consensus Matrix

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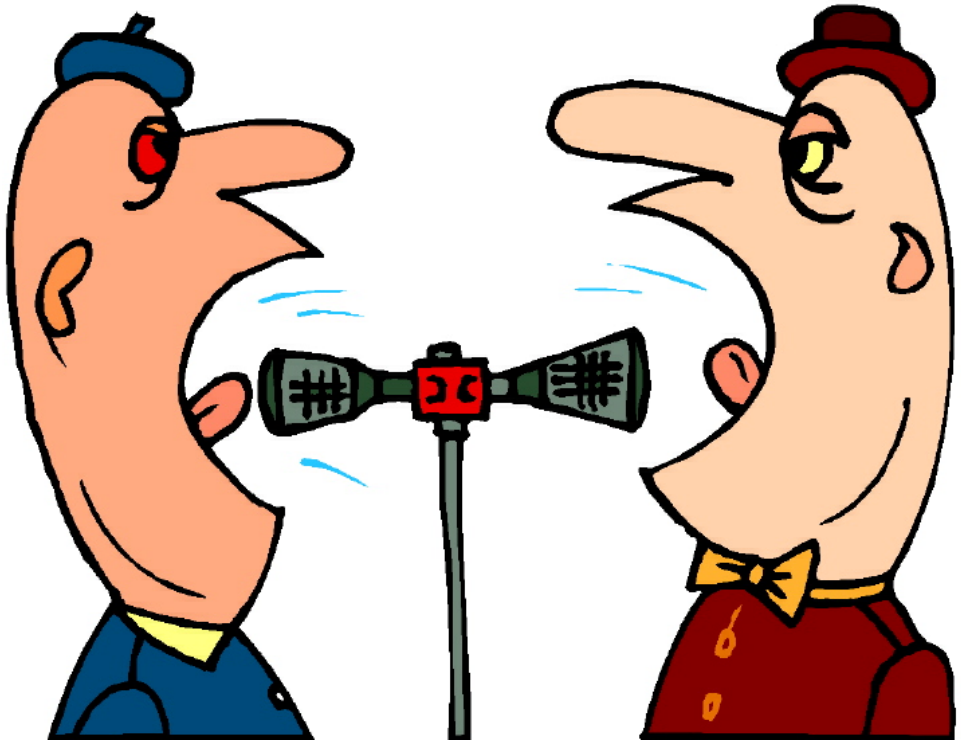
- We will collect and tabulate the answers

Debate



One heated topic in 2 groups…

Should we pursue/ask for health plan controls on prescribing such as:

- MME limits
- Requiring prior authorization for higher doses of medication
- Requiring documentation of CURES search, urine testing and signed agreement before filling meds
- Feedback to individual MDs prescribing at the edges of the Bell curve

Debaters

Kathleen Clanon, MD

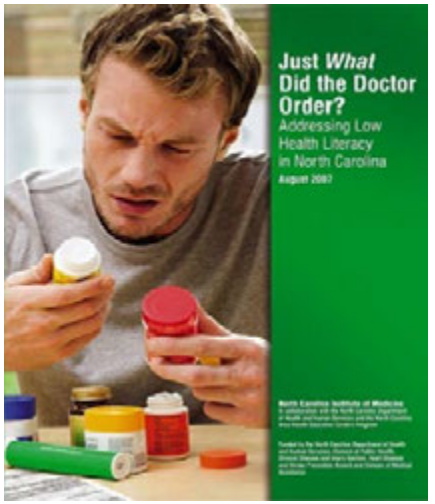
Jeffery Seal, MD

Health Plan Controls: Yes!

- It works!
  - Partnership Health Plan reported 40% decline in patients on chronic opioids after instituting controls
  - Similar decreases in Nor Cal Kaiser
  - Build flags and tools into the EHR- makes the process of MD behavior change much easier
- It's cheap, compared to hiring more pain specialists
- Rapid dissemination of best practices

Health Plan Controls: Yes!

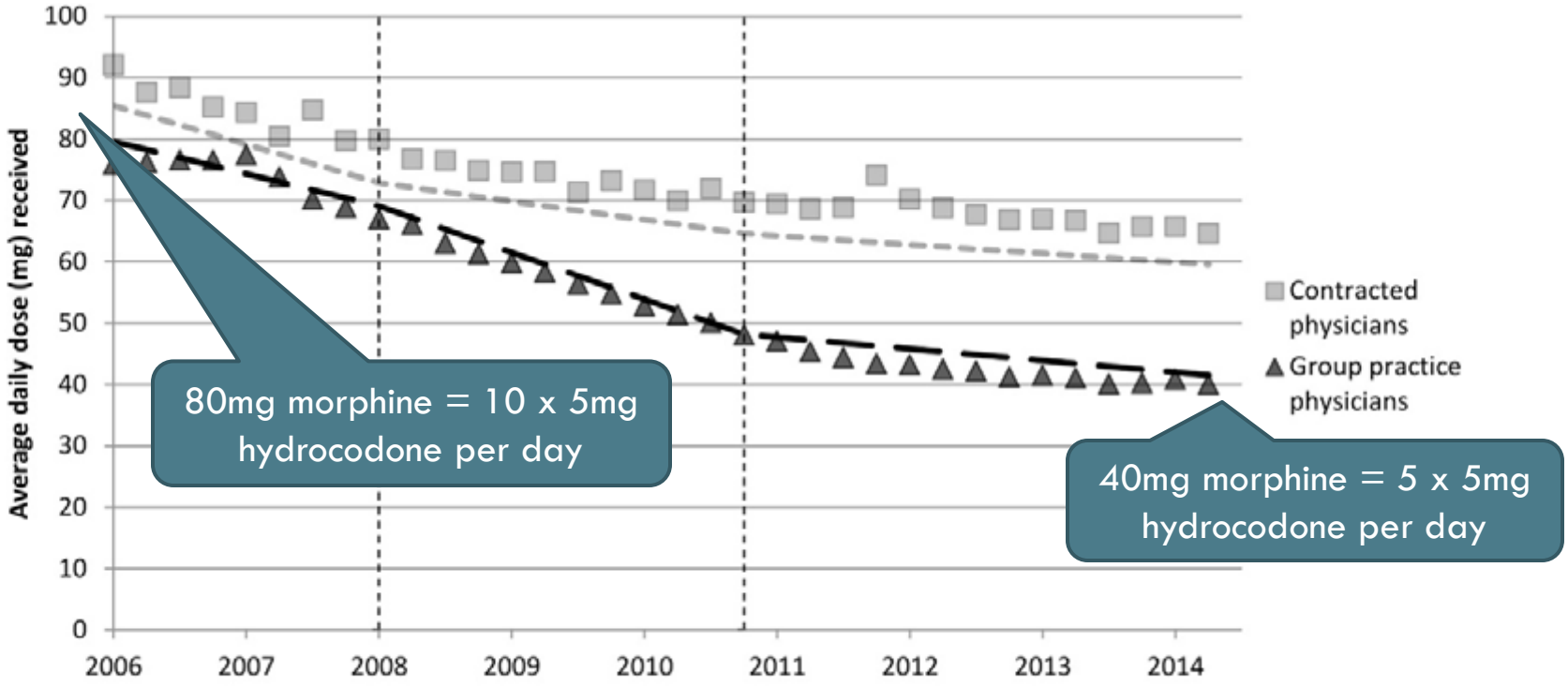
- Compared the experience of 16,653 patients in HP group vs 5,552 patients in contracted practices
- % of opioid patients receiving 120 or more mme declined
  - 16.8% to 6.3% in the group practice versus
  - 20.6% to 13.6% in pts seen by contract MDs



Health Plan Controls: Yes!

Is it really working, or is it just that we are all doing better in this area these days?

The impact of opioid risk reduction initiatives on high-dose opioid prescribing for chronic opioid therapy patients Von Korff, M. 0ct 2015 Journal of Pain



Estimated adjusted change (Δ) per year in mean daily opioid morphine equivalent dose (in milligrams).

Time for a Paradigm Shift…
It's not about us.

- Saving lives is more important than our convenience.
- Reduce the barrier to our behavior change – fewer hard conversations.
- Care is getting more connected. Health plans are part of the team.

Health Plan Controls: Hell no!

This all comes down to more paperwork

Administrative work consumes one-sixth of U.S. physicians' time and erodes their morale, researchers say

Electronic health records increase doctors' bureaucratic burden

FOR IMMEDIATE RELEASE, October 23, 2014

Contact: Mark Almberg, communications director PNHP, mark@pnhp.org, (312) 782-6006

The average U.S. doctor spends 16.6 percent of his or her working hours on non-patient-related paperwork, time that might otherwise be spent caring for patients. And the more time doctors spend on such bureaucratic tasks, the unhappier they are about having chosen medicine as a career.

Who Benefits the Most?

Patient-Centered Care is the future. This idea is the past…..

- No real attempt to tailor to specific patients
- Do we have alternatives to offer patients (Alameda County is not Sonoma…)
- "Report card" approach encourages doctors to drop patients indiscriminately, instead of making nuanced clinical assessments
- What is happening to the patients who are no longer on opioids?

Back to Sonoma County and Partnership Health Plan… What they don't tell you

Sonoma County sees drop in powerful painkiller prescriptions | The Press Democrat

Partnership HealthPlan's 40 percent drop in the use of long-acti d pain medication among its members took place despite an increase in the number of r s due to implementation of President Obama's Affordable Care Act. The plan also increase in the number of seniors and people with disabilities, who tend to use more pa ication.

This month, the health plan will begin he octors wean their patients off high doses of pain ations. Doctors will be asked to encourage non-op reduction treatments such as chiropractic servi upuncture, physical therapy, podiatry and guided tion.

Partnership lan is a community based health care organi hat contracts with the state to administer Medi-C its. The plan has more than a half-million members.

Related Stories

Audience Vote

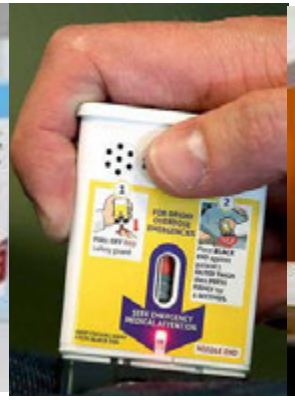
Practical approach to getting people off opioids?

OR

Dangerous cookie cutter medicine

Where We Go From Here

- Three implementation groups.
  - Clinical
  - Community
  - Data
- We need people from clinics on the community group and vice versa…..
- Groups will meet monthly to move their recommendations to reality.



Please move now to your implementation group

Clinical

Community

Data

Have an organizing meeting. Decide on your first meeting day/time.

Put your info on the sign-up sheet.