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.

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

<table>
<thead>
<tr>
<th>Location</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon Pain Guidance</td>
<td>Dose-ceiling of 120 MMEs, among other standards</td>
</tr>
<tr>
<td>National Association of Medicaid Directors</td>
<td>Recommend a dose-ceiling of 120 MMEs for member organizations</td>
</tr>
</tbody>
</table>

Pro/Con

<table>
<thead>
<tr>
<th>Consensus based process</th>
<th>Providers may perceive as overly intrusive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistency</td>
<td>Non-binding (compared with payer actions)</td>
</tr>
<tr>
<td>Standards drawn from the evidence-based</td>
<td></td>
</tr>
</tbody>
</table>

Reference
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 instance, 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.

**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**

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

**Pro/Con**

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

**Reference**
- Alameda County Public Health data. Available upon request.
- RxSafe Marin. 2013. Available at: [http://www.rxsafemarin.org/action-team--data.html](http://www.rxsafemarin.org/action-team--data.html)
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")

Examples in other places

<table>
<thead>
<tr>
<th>Location</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Diego County</td>
<td>Took leadership role in developing CA ACEP guidelines</td>
</tr>
<tr>
<td>Washington State</td>
<td>Statewide, evidence guided guidelines</td>
</tr>
</tbody>
</table>

Pro/Con

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

Reference

- 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/
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.

**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**

<table>
<thead>
<tr>
<th>Location</th>
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</tr>
</thead>
<tbody>
<tr>
<td>CHCN clinics (i.e. La Clinica, LifeLong, etc.)</td>
<td>Developed homegrown guidelines</td>
</tr>
<tr>
<td>Medical Board of California</td>
<td>Developed guidelines for management of opioids</td>
</tr>
<tr>
<td>Washington State government</td>
<td>Developed guidelines for management of opioids</td>
</tr>
</tbody>
</table>

**Pro/Con**

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

**Reference**
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.

**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**

<table>
<thead>
<tr>
<th>Location</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>La Clínica de la Raza, Alameda County</td>
<td>Behavioral health evaluation are performed on all patients being started on chronic opioid therapy.</td>
</tr>
<tr>
<td>Central City Concern, Portland Oregon</td>
<td>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</td>
</tr>
</tbody>
</table>

**Pro/Con**

| Patient-centered | Resource intensive |

**Reference**
- Personal communication with Jim Shames, MD. Jackson County, Oregon.
**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.

**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

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

## Pro/Con

<table>
<thead>
<tr>
<th>Enforceable</th>
<th>Provider resentment (perceived as too intrusive?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions can be supported by evidence base</td>
<td>Disagreement on particular actions to adopt</td>
</tr>
<tr>
<td></td>
<td>Medicaid regulations that impede integrated care solutions</td>
</tr>
</tbody>
</table>

## Reference

- Partnership HealthPlan of California. Managing pain safely. Available at: [http://www.partnershiphp.org/Providers/HealthServices/Pages/Managing-Pain-Safely.aspx](http://www.partnershiphp.org/Providers/HealthServices/Pages/Managing-Pain-Safely.aspx)
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).

**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**

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

**Pro/Con**

<table>
<thead>
<tr>
<th>Patient-centered</th>
<th>Resource intensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-based (naloxone)</td>
<td>Poor evidence (take-back, patient education)</td>
</tr>
</tbody>
</table>

**Reference**