



California Health Care Foundation



Better, Safer Pain Management:
Resources for Residency Programs
to Address the Opioid Epidemic

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About the Authors

Kristene Cristobal, principal of Cristobal Consulting, works with health care and community health organizations and provides strategic planning, program development and implementation, training, and quantitative and qualitative assessment services. Prior to forming Cristobal Consulting, she worked at Kaiser Permanente, where she directed a team that contributed to KP's strategy for a performance improvement system, infrastructure and capability building.

California Improvement Network

Better Ideas for Care Delivery

About California Improvement Network

The California Improvement Network (CIN) is a community of health care professionals sharing techniques to improve the patient experience and the health of populations while lowering the cost of care.

About the Foundation

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Introduction

The purpose of this document is twofold: to provide a framework for creating a safer prescribing culture in residency clinics and to provide examples of teaching tools for residents related to primary care pain management and safer opioid prescribing. The materials and approaches presented are informed by the experiences of nine primary care residency programs (see below), each of which participated in a nine-month residency action group (“action group”), consisting of two in-person convenings, several webinars, monthly coaching calls, and completion of an improvement project.

Background

The Opioid Epidemic

The overuse of opioid medications was declared an epidemic by the US Centers for Disease Control and Prevention (CDC) in 2011. Overdose deaths from opioids increased steadily over the last two decades, nearly quadrupling between 1999 and 2013.¹ Drug overdose-related deaths now exceed deaths from motor vehicles and firearms in the United States, and prescription opioid overdose deaths exceed those from cocaine and heroin combined.² Hospital admissions for opioid addiction treatment have increased fivefold,³ as have related medical complications such as nonfatal overdoses, falls and fractures, drug-drug interactions, fatal heart rhythm disturbances, and neonatal abstinence syndrome, which often requires prolonged stays in intensive care.⁴

The steady increase in the use of opioid medications over the last two decades was seeded mainly by the pharmaceutical industry. In the 1990s, pharmaceutical companies aggressively marketed new, stronger, longer-lasting opioids with misleading claims about low addiction risk. The American Pain Society, heavily funded by Purdue, the maker of OxyContin,⁵ and by other pharmaceutical companies, initiated a campaign in 1996 to encourage providers to assess pain at every patient visit. This “pain as a fifth vital sign” approach was adopted by the Department of Veterans Affairs⁶ and by the Joint Commission, which accredits over 20,000 health care organizations. Although pain control did not improve,⁷ the fifth vital sign campaign contributed to opioid prescribing practices reaching levels previously only seen in hospice care.⁸

Primary care providers are the source of most opioid prescriptions. Ongoing efforts across the country are focused on changing prescribing cultures in primary care and on encouraging more judicious prescribing and better assessment of the true risks and benefits of opioids in chronic pain. If prescribing cultures are to change, primary care residencies need to be part of the strategy, so that new doctors emerge with the knowledge and skills they need.

Residency Program Action Group

Residency programs offer a rich opportunity for shaping the practice of new physicians. However, residency programs face a number of challenges when it comes to leading culture change: few administrative resources for implementing new projects; insufficient curricular coverage of chronic pain management, addiction, and opioid safety; and staffing challenges (attending physicians, residents, and staff are often salaried by different organizations, without aligned accountability, and most faculty and residents only work in clinic 4 to 12 hours a week). Culture change is difficult when no one is in the same place at the same time.

The California Health Care Foundation’s California Improvement Network (CIN) supports action groups to explore, experiment with, and put into practice new ideas in care delivery. Action groups are designed to accelerate work on key issues through coaching from expert faculty, networking with peers tasked with the same issue, and focused training to help reach improvement goals. In the summer of 2015, the CIN created a nine-month residency action group consisting of primary care residency programs; it focused on developing both new training curricula for safer prescribing and tools to support culture change related to safer pain management in teaching clinics. Expert faculty and an improvement coach supported the participants throughout the program, which involved monthly webinars, two in-person trainings, and monthly coaching calls.

The following nine programs participated:

- ▶ Contra Costa Regional Medical Center Family Medicine Residency
- ▶ Highland Hospital Internal Medicine Residency (Alameda County Health System)

- ▶ Loma Linda Inland Empire Consortium for Healthcare Education Family Medicine Residency
- ▶ Natividad Medical Center Family Medicine Residency (Monterey County)
- ▶ Santa Rosa Family Medicine (University of California, San Francisco [UCSF] affiliate) Residency
- ▶ UCSF Fresno Family and Community Medicine Residency
- ▶ Valley Family Medicine Residency of Modesto
- ▶ Ventura County Medical Center Family Medicine Residency
- ▶ White Memorial Family Medicine Residency (Los Angeles)

This document shares the strategies and experiences of these nine programs in two key areas: improving infrastructure for a safer prescribing culture and strengthening curriculum for teaching residents, to reflect new evidence regarding the management of chronic pain patients.

Infrastructure to Support a Safer Prescribing Culture

The core component of a safer prescribing culture is the agreement by attending physicians and residents to make decisions according to evidence, and to respond to common situations, such as requests for early refills or dose escalations, in similar ways.

The following core strategies were emphasized in the residency action group.

Create Clinical Guidelines for the Judicious Use of Opioids

Acute Pain Management

The simplest way to prevent opioid overdose deaths and addiction is to be cautious about starting people down the path of long-term use, since most chronic opioid use emerges from acute use that never stopped. In a study of 3 million health plan members, 67% of patients given

opioids for 90 days for acute pain were still taking the opioids two years later.⁹ Guidelines should emphasize the importance of avoiding opioids for conditions that the evidence shows poor benefit or high risk (uncomplicated low back pain,¹⁰ fibromyalgia, and headaches¹¹), give a small supply (e.g., 3 to 7 days, not a month), and give low doses.

Strategies:

- ▶ Create common standards about diagnoses where benefit is greater than risk.
- ▶ Create common standards about the typical acute dose and duration of treatment (e.g., 3 to 7 days).
- ▶ Teach residents about nonopioid strategies for acute pain management.
- ▶ Work on systems to facilitate easy, urgent referral for physical or occupational therapy for acute back pain to focus on mobility and function rather than opioid use. Consider embedding a physical or occupational therapist in the clinic to manage all acute low-risk low back pain, focusing on early functional recovery.

Chronic Pain Management

Evidence is accumulating that some of the information taught 20 years ago was untrue, and often deliberately misleading (executives at Purdue, for example, paid criminal fines for falsifying medical evidence and using misleading advertising). A more recent study showed that of patients using opioids for chronic pain, 25% to 35% develop addiction, and the evidence supporting benefit (in terms of long-term pain relief) is poor.¹² Evidence is accumulating that long-term use of opioids, especially at high doses, increases risks of hypogonadism (with associated sexual dysfunction and low bone density), mood disorders, decreased function and lower return-to-work rates, sleep apnea, and worsened pain (either due to hyperalgesia or recurrent withdrawal symptoms between doses, a problem especially with OxyContin).

Guidelines can help clinicians learn about new evidence and practice according to it. The CDC published new guidelines¹³ in 2016 with accompanying literature review and practice checklists that can be used as a foundation for residency practices.¹⁴ More importantly, guidelines can help ensure all avoid regimens that put patients at unacceptable risks of death: high daily opioid doses (new CDC guidelines use >90 mg morphine equivalents a day or >40 mg methadone a day as an unsafe threshold),

combination benzodiazepines and opioids, and/or use of multiple prescribers or pharmacies.

RESULTS: The number of residency programs implementing clinical practice guidelines increased from three (33%) to eight (89%) after the program. The number of programs that have agreement among clinicians regarding a maximum recommended opioid dose increased from 33% to 66%, and the agreement about avoiding co-prescribing of benzodiazepines increased from 44% to 80%.

Standardize Clinical Approaches to Common Situations

It is common for patients in residency clinics to be seen by multiple providers who may have varying or conflicting treatment plans — this is confusing to patients, as well as to the clinicians who treat the patient. Clinics can prevent miscommunication and minimize patient confusion by getting buy-in on common approaches to common situations. Establishing consistent practices ensures that patients are not treated differently based on the attending on duty. Patients receiving consistent messages are able to plan for refills and do not receive reinforcement for behaviors that feed addiction (such as refilling lost or stolen medications). Common situations meriting guidelines include:

► **Early refill requests.** When a patient's refill runs out early, this may indicate increased use of the medication due to a pain flare or new injury, lack of control due to addiction, or diversion for illegal sale or use by others. These factors are difficult for staff or covering providers to distinguish. Common clinic responses to early refill requests include: (1) inform patients that early refills are not provided, and patients need to manage their pain within their existing medication supply; (2) allow one "pass" for an early refill, once per year, which is noted in the chart; and (3) use contingency management, meaning that the medications are refilled but at a 10% lower daily dose, which is continued on an ongoing basis. (This approach allows patients to avoid an ED visit due to severe withdrawal symptoms, but also does not reward losing control of opioids through getting

early refills for the same amount.) Clinics without clinician agreement about refills leave providers to make these decisions on their own, and to determine "legitimate" from "illegitimate" requests, a role for which they are untrained and which can cause resentment among providers.

- **Unexpected urine drug screen result.**¹⁵ Clinicians have difficulty interpreting urine drug screening¹⁶ because of the high incidence of false positives (lack of understanding of opioid metabolites or oversensitive screens that create false positives for methamphetamines) or false negatives (due to high detection thresholds). Because these tests are easy to misinterpret, residencies should communicate with the laboratory to understand the basic screening panel and have protocols for interpretation of results based on the standard panel and thresholds used by the clinic laboratory. Residencies should establish standard responses to unexpected results: For example, never fire the patient; if opioids are to be discontinued, ensure adequate taper or referral into buprenorphine or methadone treatment. Clinicians who are trying to figure this out on the fly can unfairly discontinue patients who are not using their medications inappropriately, or lead them to tolerate high-risk behavior without acting to manage the risks.
- **Surprising CURES reports.** The Controlled Substance Utilization Review and Evaluation System (CURES) database is maintained by the state Department of Justice and contains all controlled prescriptions dispensed in California. Providers can check the CURES database to see if their patients have multiple prescriptions for opioids through other providers or pharmacies. The CURES 2.0 system contains alerts for five high-risk scenarios to help providers identify patients potentially at risk (morphine equivalent dose >100 mg, methadone dose >40 mg, continuous daily opioid use 90 or more days, use of six or more prescribers or pharmacies in six months, combined use of opioids and benzodiazepines). CURES reports showing patients with multiple prescribers are a concern, since these patients are at high risk of overdose death.¹⁷ Guidelines can help clinicians ask appropriate questions before making a decision, since not all cases of multiple prescribers are signs of addiction.) CURES 2.0 allows prescribers to communicate with each other securely within the system to gather more information to inform management.

► **Signs of substance use disorder.** Addiction in the context of chronic opioid use is common — 10% to 35% of patients on long-term opioids develop addiction, depending on the study, so clinics need standard practices to identify addiction (e.g., SBIRT: Screening, Brief Intervention, and Referral for Treatment) and need to develop internal or external resources for medication-assisted treatment. Abruptly discontinuing opioids for patients who are dependent can put them at high risk for a negative outcome. To prevent such outcomes, patients should be offered opioid agonist treatment (buprenorphine or methadone) instead of being cut off from opioids or fired from the practice. Patients abruptly cut off of opioids without other options are at risk of turning to heroin, with the resulting risks of hepatitis C, HIV, and/or overdose.

► **Management of tapering regimens.** Although many tapering regimens may appear simple (e.g., decrease dose by 10% per month), implementing a tapering plan can be quite complex. How to work with a health plan to ensure access to the right dose of tablets during a long taper? How to manage patients who do not want to taper, or who have withdrawal symptoms during tapers? What are common pearls of wisdom (such as never taper during the winter holidays) that help patients and providers achieve peace of mind? Examples of tapering protocols include the one discussed in a lecture by Kaiser Permanente pain specialist Andrea Rubinstein, MD; a tapering toolkit available on Partnership HealthPlan of California's Managing Pain Safely website; and a tapering guide from the COPE opioid training website.¹⁸

RESULTS: Residency programs implemented new workflows to ensure consistent routine care, such as training medical assistants to run CURES reports at the time of any refill visit and working with the lab to ensure the correct drug screen was in place (to avoid misinterpretations of false negatives or false positives). One residency implemented a Share the Care model, with clearly defined roles for each member of the care team, to ensure the right care happened consistently.

Risk Screening Tools: Use at Your Own Risk

Standardized risk assessments were reviewed in the action group, such as the Opioid Risk Tool and the Diagnosis, Intractability, Risk, and Efficacy (DIRE) tool. However, the 2016 CDC guidelines reviewed the literature and found little to no support for these tools, due to the potential harms of inaccurate risk stratification (both in under- and overestimation of risk). Clinicians are extremely inaccurate in their assessment of diversion and opioid misuse,¹⁹ and tools to predict risk at the onset of opioid therapy have not been shown to decrease risks of addiction and/or overdose deaths.

Monitor Adherence to Clinic Guidelines and Protocols

Creating protocols can be simple; ensuring that they are followed is not. High-performing clinics put in systems to monitor compliance with guidelines, either through registry reports or routinely scheduled chart review, and give feedback. Peer review (residents or attendees meeting to review a select few of their colleague's charts, comparing against a guideline checklist, and discussing the results) can be an effective way to reinforce the guidelines and their importance. Some clinics run blinded or unblinded reports from their registry, displaying individual or team results on metrics such as presence of pain management agreement, use of urine drug screening, number of patients on high-dose opioids, average daily dose of patients on chronic opioids, etc. Comparative data has been shown to be a **powerful motivator of physician behavior change**.

RESULTS: Registries are useful tools to monitor adherence to clinical guidelines. Seventy-eight percent of residencies had registries in place for chronic pain after the program, compared to 11% beforehand.

Routinely Document Functional Status and Functional Goals

Since chronic pain is rarely cured but rather requires chronic management, patients should be informed that the goal of opioid treatment is to improve function. Goals should be established, and progress against these goals monitored, so that opioids can be discontinued if function is not improving. The prospect evaluation grid (PEG) score is a commonly used tool, where patients rate their average pain intensity, interference with enjoyment of life, and interference with general activity.²⁰ Changing numbers over time can serve to document changes in function. Clinicians can set activity goals (such as ability to walk to the store or around the block). Documentation of goals, and progress against these goals, is recommended both by the Medical Board of California and the CDC.

Screen for and Treat Behavioral Health Conditions

Behavioral health is an important component of ongoing opioid therapy management and of chronic pain management in general. Behavioral health issues, such as depression and trauma, can have significant impact on patients' ability to manage their pain and on how they experience their pain. Untreated behavioral health conditions can worsen pain²¹ and put patients at increased risk of overdose death.²² Behavioral health treatments, such as cognitive behavioral therapy and mindfulness-based stress reduction techniques, have been proven effective in treatment of chronic pain.²³

RESULTS: Due to financial limitations, adding behavioral health resources was challenging for the residency programs. Eleven percent had behavioral health resources focused on chronic pain prior to the action group, compared to 33% afterward.

Offer Group Visits

Group visits for chronic pain patients are increasingly used, with multiple benefits:

- ▶ Educating patients on a variety of topics (understanding neurophysiology of pain, mind-body connections, nonmedical strategies for pain relief, coping with pain flairs, anticipating triggers, managing stressors, improving function, starting gentle exercise regimens, naloxone use, and decreasing overdose risk)
- ▶ Decreasing social isolation and expanding social networks
- ▶ Removing the focus of the visit from dose escalation to improved function
- ▶ Decreasing the impact on clinic access due to multiple visits from chronic pain patients

RESULTS: Group visits can be facilitated by the prescriber; alternatively, if facilitated by an educator or behavioral health clinician, the prescriber can pull patients out for brief individual visits to manage prescriptions.

Co-Prescribe Naloxone

Naloxone, an opioid antidote, can reverse the effect of an overdose and save lives. Increased naloxone availability is correlated with lower community overdose rates.²⁴ Co-prescribing naloxone to patients on long-term opioids improves the likelihood that this life-saving medication is available to the patient or to the patient's caregivers or family members. The conversation about naloxone (and opioid risks) has been shown to decrease overdose deaths even when naloxone is prescribed but not used.²⁵

RESULTS: One residency program implemented nurse teaching visits during which a nurse works with a patient on how to use naloxone. No programs routinely prescribed naloxone prior to the action group, compared to 33% afterward.

Set Up an Opioid Review Committee

Opioid review committees ideally consist of multiple disciplines (medical, nursing, behavioral, administrative, addiction) and meet regularly to review cases that are either selected through report (e.g., patients on high-dose opioids or with an abnormal urine drug screen) or through referral (e.g., when a provider wants assistance with a complex patient). Committees should have a standard review process, such as a checklist that compares care against the clinic's guidelines, which provides an opportunity to discuss complex cases and brings in opinions from different disciplines, as well as a mechanism to provide feedback to the clinician, ideally in the medical record. This structure allows prescribers to reference clinic policy, or a decision by an independent review body, when providing a recommendation to a patient, rather than having to defend a difficult treatment decision without backup.

RESULTS: Some residency programs implemented opioid review committees during the action group and reported that these structures were helpful support for providers in making tough decisions.

Ensure Access to Buprenorphine

Many safety-net patients on chronic opioid therapy are not easily categorized as “purely chronic pain” or “purely addiction.” In addition, many patients with opioid addiction start as patients using opioids for acute or chronic pain. At minimum, residents and attendings should know about addiction treatment resources in their community, including buprenorphine prescribers and narcotic treatment programs (methadone clinics). Ideally, since communities rarely have sufficient addiction treatment resources, residency clinics will start to provide buprenorphine in-house. Buprenorphine is a partial opioid agonist that has been shown to increase recovery rates (67% compared to 25% with drug-free treatment) and decrease overdose deaths (a randomized trial of buprenorphine compared to placebo showed a 20% death rate in the placebo arm within the first year of treatment, with no deaths in the buprenorphine arm). (For more information, read *Recovery Within Reach*, a California Health Care Foundation [CHCF] publication reviewing the

evidence for buprenorphine treatment in primary care settings, and the components needed for successful integration.)²⁶ Buprenorphine prescribed for addiction requires a waiver, obtained through an eight-hour in-person or online training. (See the Substance Abuse and Mental Health Service Administration [SAMHSA] website for training resources.)²⁷ The Vancouver Health Clinical Guidelines,²⁸ published in 2015, is a thorough review of the evidence for medication-assisted addiction treatment for opioid use disorder.

RESULTS: Integrating buprenorphine into residency clinics was not a major focus of the action group, and most residencies reported challenges doing this. Some residencies indicated that some members of their faculty were in the process of obtaining waivers.

Offer Multimodal Approaches for Pain Management

In busy and/or under-resourced clinics, it can be much easier to prescribe opioids than to develop multimodal treatment plans, especially when opioids are covered by insurance, and physical medicine or alternative medicine may not be covered. Many pain conditions worsen with inactivity, yet patients often have difficulty increasing physical activity while coping with pain and may get discouraged when increased activity results in pain flares. Some clinics address this by embedding physical or occupational therapists into clinics, to coach patients on how to increase activity gently and safely, or provide group back pain or pain management classes. Providers are less likely to start new patients on opioids, and more likely to support dose tapers, if they have other pain management resources to offer.

RESULTS: Implementing complementary, alternative, and other nonopioid approaches to pain management is challenging to residency programs that are typically on tight budgets. Thirty-three percent of programs had multimodal programs in place prior to the action group, compared to 67% afterward. See CHCF report *Pain Care on a New Track: Complementary Therapies in the Safety Net*, for descriptions of community health centers that were able to integrate new pain treatment approaches.²⁹

A Strong Curriculum for Pain Management and Opioid Safety

Expert faculty presented curriculum topics in a “Train the Trainer” model, so participating clinics could adapt the materials for their own use and create an ongoing curriculum to teach the basics of primary care pain management and safer opioid prescribing practices.

This document is not intended to be an enduring, comprehensive resource; rather, it will share resources and presentations used during the action group, often in response to requests from participants. Pages 9 to 13 provide a reference to all the webinars with links including the slide decks (which can be downloaded and modified) as well as recorded lectures, where available.³⁰

Residency leaders shared the approaches that worked best: interactive discussions instead of lectures, role plays to learn how to manage tough conversations, and motivational interviewing training, among others. The Santa Rosa Family Medicine Residency Program created [Clinical Learning in Practice Sessions \(CLIPS\)](#), twelve 30-minute pre-clinic teaching sessions, on topics including pain, addiction, opioids, alternatives, and limiting overdose. The program conducted pre- and post-surveys that showed residents felt less overwhelmed and more confident in managing chronic pain, addiction, and opioids.

Webinar 1 WATCH

JUNE 2015

Core Components of Safe Clinic Culture and Resident Teaching

Faculty

Diana Coffa, MD, Residency Director, UCSF/
San Francisco General Hospital (SFGH) Family
Medicine Residency Program

Kelly Pfeifer, MD, Director, High-Value Care, CHCF

Key Elements/Takeaways

- ▶ Rationale for standardized clinic practices to support a culture of safe prescribing
- ▶ Strategies to get providers on board
- ▶ Sample clinical guidelines and policies
- ▶ Structure for opioid review committee (pain squad reviews high-risk cases, abnormal urine drug screens, or referrals from providers and also develops clinic policies and manages pain-related improvement projects)
- ▶ How to run a chronic pain group (structure, educational topics, roles)
- ▶ Sample didactic structure:
 - ▶ 2-hour intern immersion (understanding chronic pain, poor evidence supporting long-term opioid therapy, risks of treatment, safety and monitoring)
 - ▶ Yearly pain management lectures for all residents: safer opioid prescribing basics, urine drug screen interpretation, clinical cases (responding to concerning behaviors), motivational interviewing
 - ▶ SBIRT and motivational interviewing curriculum (16 hours, R2&R3): motivational interviewing techniques and practice, with role plays, peer-peer feedback, and fishbowl exercises; booster sessions on chronic pain and difficult conversations; trauma-informed care basics
 - ▶ Medication-assisted treatment (buprenorphine): didactics (8-hour waiver course); site visit at induction clinic; one-on-one case discussions, chart review, observation, and feedback
- ▶ Review of nonopioid treatments (medications, physical/functional, complementary and alternative, cognitive and behavioral)

Resources

- ▶ UCSF Pain Squad Referral Form [READ](#)
- ▶ UCSF Pain Squad Options for Recommendations [READ](#)
- ▶ SFHP / Family Health Center Policy on the Use of Opioids for Chronic Pain [READ](#)

Webinar 2 [WATCH](#) JULY 2015 Neurobiology of Pain and Addiction

Faculty

Corey Waller, MD, Director, Center for Integrative Medicine, Grand Rapids, Michigan (recorded lecture)

Sharone Abramowitz, MD, Director, Behavioral and Addiction Medicine, Highland Hospital

Kelly Pfeifer, MD, Director, High-Value Care, CHCF

Key Elements/Takeaways

- ▶ Neurobiology of addiction: how long-term opioids change the dopamine axis (the reward center of the brain) and therefore change behavior; long-term and sometimes permanent changes
- ▶ How understanding neurobiology can increase compassion and decrease scorn when faced with common symptoms of uncontrolled addiction: lying, manipulating, lack of control
- ▶ The case for buprenorphine, based on brain chemistry
- ▶ Review of the evidence (and lack of evidence) supporting long-term opioid treatment
- ▶ Diagnosing substance use disorders (understanding DSM-5 criteria)
- ▶ Basics of integrating buprenorphine into primary care (more in-depth session later in action group)
- ▶ Understanding epigenetics and the role of adverse childhood experiences (ACEs) in long-term health and outcomes

Resource

Waller, Corey. Center for Integrated Medicine. "Yes, You Can! Improving Outcomes in Pain Management and Addiction," November 14, 2013 presentation at the Community Care Team Summit in Grand Rapids, MI.

[WATCH](#)

Webinar 3 [WATCH](#) AUGUST 2015 Basics of QI and Application for Safe Prescribing Culture in Residency Programs

Faculty

Kristene Cristobal, MS, Cristobal Consulting

Diana Coffa, MD, Residency Director, UCSF/SFGH Family Medicine Residency Program

Key Elements/Takeaways

- ▶ Making the case for quality improvement (QI): What's in it if for me?
- ▶ What is QI? Change at system level, at frontline level; regular, ongoing assessment and measurement; reduction of variability; process focused (not good/bad actors)
- ▶ Model for Improvement: shorter, action-oriented timeframes; 90-day cycles of improvement; Plan/Do/Study/Act (PDSA) cycles; fail early and often; what can you do next Tuesday?; the need for incremental change and immediate performance measures
- ▶ How to use data: data for improvement, not auditing or research; dynamic, not static view of measures; how to use run charts
- ▶ SMART goals (specific, measurable, achievable, relevant, time-limited)
- ▶ Managing change, managing people: the Everett Rogers technology adoption curve
- ▶ Cultivating thought leaders and early adopters
- ▶ Burning platform — communicating change

Resources

- ▶ Institute for Healthcare Improvement. "How to Improve." [READ](#)
- ▶ Institute for Healthcare Improvement whiteboard videos:
 - ▶ "Model for Improvement Clip 1." [WATCH](#)
 - ▶ "Model for Improvement Clip 2." [WATCH](#)
 - ▶ "PDSA in Everyday Life." [WATCH](#)
- ▶ Langley, Gerald J. et al. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. 2nd ed. San Francisco: Jossey-Bass, 2009.

- ▶ Solberg, L. I., G. Mosser, and S. McDonald. "The Three Faces of Performance Measurement: Improvement, Accountability, and Research." *Joint Commission Journal on Quality Improvement* 23, no. 3 (March 1997): 135-47.

Webinar 4 WATCH SEPTEMBER 2015 Teaching Residents Basic Behavioral Health Management in Resource-Poor Settings

Faculty

Sharone Abramowitz, MD, Director, Behavioral and Addiction Medicine, Highland Hospital

Diana Coffa, MD, Residency Director, UCSF/SFGH Family Medicine Residency Program

Key Elements/Takeaways

- ▶ Importance of screening and treating comorbidities, such as depression, post-traumatic stress disorder, and anxiety
 - ▶ Operationalizing PHQ2 and PHQ9s in clinic (patient health questionnaires)
 - ▶ Understanding the post-traumatic stress disorder checklist
- ▶ Understanding alternatives to the high-risk combination of opioids and benzodiazepines
 - ▶ Alternatives for treating anxiety
 - ▶ Don't create new starts
 - ▶ Teaching how to wean patients off of benzos, opioids, or both
 - ▶ Teaching sleep hygiene (better sleep practices, cognitive behavioral therapy for insomnia)
- ▶ How to teach mindfulness during short visits
 - ▶ Evidence supporting mindfulness-based stress reduction (MBSR)
 - ▶ How to teach MBSR in short sessions
 - ▶ Teaching mindfulness-based relapse prevention and mindfulness-oriented recovery enhancement methodology (for addiction)
 - ▶ Teaching "soft belly" breathing

- ▶ Group visits
 - ▶ Orientation groups (basic education about how the practice works, health education)
 - ▶ Medication groups for refill management, include brief support and treatment; education on strategies for managing pain; and information on the impact of medications
 - ▶ Psychoeducational and therapeutic groups: cognitive behavioral therapy (CBT), acceptance and commitment therapy (ACT), or MBSR

Resources

Scheidt, Susan and Diana Coffa. *Body and Soul: A Path Toward Healing from Chronic Pain*. San Francisco Department of Public Health. June 2013. READ

References

Key finding. Early case series found over half of chronic pain patients had 33%+ reduction in current pain and body problems after mindfulness meditation training.

Kabat-Zinn, Jon. "An Outpatient Program in Behavioral Medicine for Chronic Pain Patients Based on the Practice of Mindfulness Meditation: Theoretical Considerations and Preliminary Results." *General Hospital Psychiatry* 4, no. 1 (April 1982): 33-47. READ

Key finding. Meditation-based program may improve ability to cope with stress and pain, with gains lasting up to four years.

Kabat-Zinn, Jon et al. "Four-Year Follow-Up of a Meditation-Based Program for the Self-Regulation of Chronic Pain: Treatment Outcomes and Compliance." *Clinical Journal of Pain* 2, no. 3 (1986): 159-73. READ

Key finding. Compliance rate for psychological therapies in management of chronic pain, despite promoting daily practice, compares favorably to other behavioral pain management approaches.

Sturgeon, John A. "Psychological Therapies for the Management of Chronic Pain." *Psychology Research and Behavior Management* 7 (April 10, 2014): 115-24. doi:10.2147/PRBM.S44762.

Key finding. Promising evidence for management of fibromyalgia and low back pain with yoga.

Lauche, R. et al. "A Systematic Review and Meta-Analysis of Mindfulness-Based Stress Reduction for the Fibromyalgia Syndrome." *Journal of Psychosomatic Research* 75, no. 6 (December 2013): 500-510. doi:10.1016/j.jpsychores.2013.10.010; Cramer, Holger et al. "Mindfulness-Based Stress Reduction for Low Back Pain. A Systematic Review." *BMC Complementary and Alternative Medicine* 12 (September 25, 2012): 162. doi:10.1186/1472-6882-12-162.

Webinar 5 READ NOVEMBER 2015
Teaching Engagement with Chronic Pain Patients Using MI and a Multimodal Approach

Faculty

Sharone Abramowitz, MD, Director, Behavioral and Addiction Medicine, Highland Hospital

Kelly Pfeifer, MD, Director, High-Value Care, CHCF

Diana Coffa, MD, Residency Director, UCSF/SFGH Family Medicine Residency Program

Key Elements/Takeaways

- ▶ Teaching residents how to engage with chronic pain patients using motivational interviewing (MI) and other approaches that give patients a higher likelihood of adopting self-care strategies
- ▶ Educational strategies to engage patients in self-care, including the gate theory of pain
- ▶ Helping patients understand multiple (nonopioid) approaches to pain management

Resources

Abramowitz, Sharone et al. "Linking a Motivational Interviewing Curriculum to the Chronic Care Model." *Journal of General Internal Medicine* 25, suppl. 4 (September 2010): S620-26. doi:10.1007/s11606-010-1426-6. READ

Webinar 6 WATCH DECEMBER 2015
The Art and (Very Little) Science of Tapering Opioid Medications

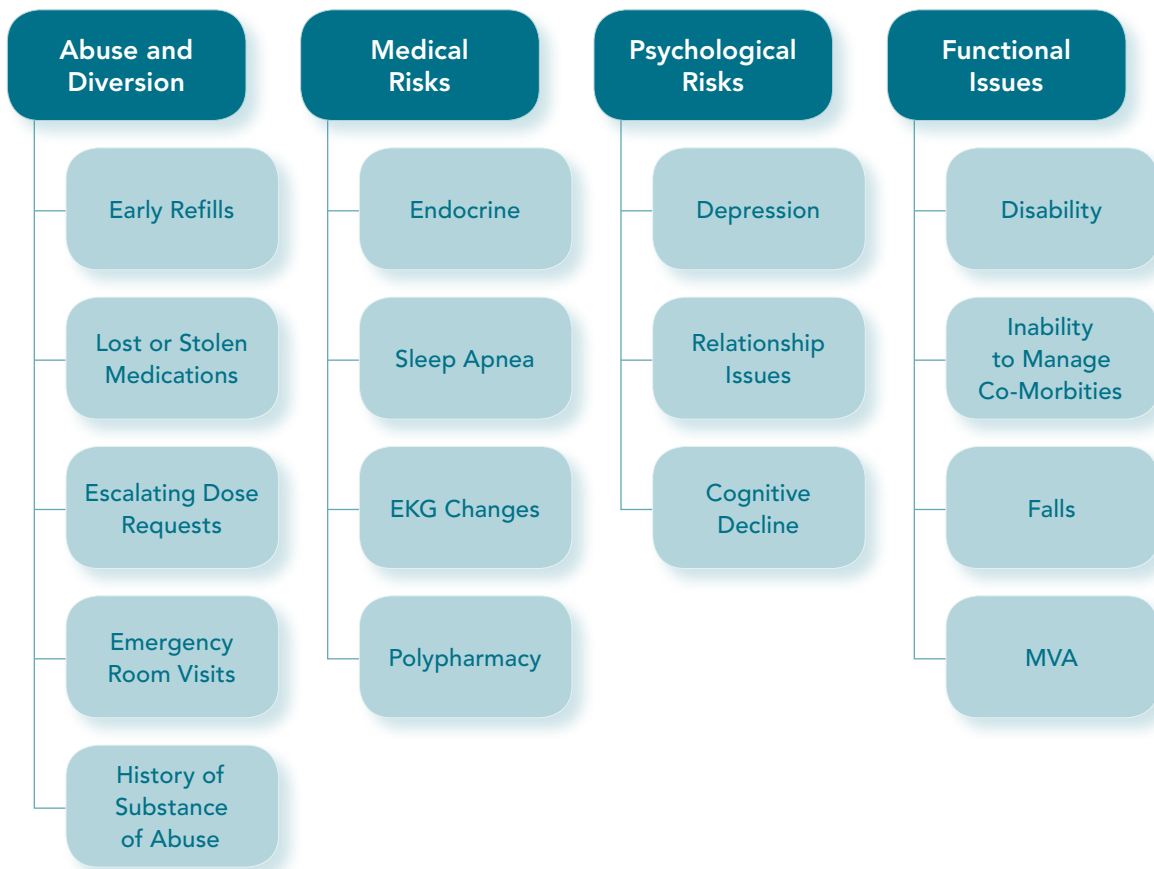
Faculty

Andrea Rubinstein, MD, Kaiser Santa Rosa Medical Center, Chief, Department of Chronic Pain, Department of Anesthesiology; Local Research Chair — Santa Rosa Assistant Clinical Professor of Family and Community Medicine, UCSF

Key Elements/Takeaways

- ▶ Learning to identify situations in which tapering is appropriate:
 - ▶ Discussing with patient the medical risks versus benefits (see Figure 1 on page 13)
 - ▶ Keeping in mind the central goal: making the patient better; lower dose is as good as "off" opioids
- ▶ Designing an appropriate taper type:
 - ▶ The longer on opioids, the slower the taper
 - ▶ Most people tolerate 10% a month; people rarely tolerate 25%
 - ▶ Using low-dose pills to create a simple taper
- ▶ Troubleshooting:
 - ▶ Modifying the taper as appropriate: first third is easiest, last third is most difficult
 - ▶ Never taper during the winter holidays (maintain stable dose)
 - ▶ Understanding withdrawal and the need for continual reassurance

Figure 1. Medical Risks of Opioid Use



Source: Andrea Rubinstein, MD, Kaiser Santa Rosa Medical Center.

Webinar 7 READ JANUARY 2016
Buprenorphine: Evidence for Its Use and How to Implement a Program

Faculty

Marwan Haddad, MD, MPH, AAHIVS, Medical Director, Center for Key Populations, Community Health Center, Connecticut

Key Elements/Takeaways

- ▶ Understanding the evidence for and benefits of integrating buprenorphine in primary care clinics
- ▶ Why primary care needs to offer office-based buprenorphine treatment
- ▶ Core elements needed to establish a buprenorphine treatment program in primary care

Resources

Substance Abuse and Mental Health Services Administration. "Buprenorphine Training for Physicians." Last modified July 7, 2016. READ

Masters, Barbara and Mary Rainwater. *Recovery Within Reach: Medication-Assisted Treatment of Opioid Addiction Comes to Primary Care*. CHCF (March 2016). READ

Buprenorphine: Questions and Answers. CHCF (June 21, 2016). READ

Webinar 8 READ Nonopioid Pain Management

FEBRUARY 2016

Faculty

Scott Fishman, MD, Chief, Division of Pain Medicine,
Department of Anesthesiology & Pain Medicine,
UC Davis

Key Elements/Takeaways

- ▶ Project ECHO (Extension for Community Healthcare Outcomes): a case-based, interactive, video tele-mentoring program that builds skills for primary care providers in pain management and safer opioid prescribing
- ▶ Examples of modules covered in ECHO curriculum:
 - ▶ Module 1. Intro to Pain and Mental Health
 - ▶ Module 2. Pain Management Essentials
 - ▶ Module 3. Opioids
 - ▶ Module 4. Back and Neck Pain
 - ▶ Module 5. Headaches and Other Pain Syndromes
 - ▶ Module 6. Diagnostic Testing
- ▶ Looking at data over time and taking a dynamic, not static, view of measures
- ▶ Displaying data using run charts with regular, ongoing assessment

Resource

Fishman, Scott M. et al. "Core Competencies for Pain Management: Results of an Interprofessional Consensus Summit." *Pain Medicine* 14, no. 7 (July 2013): 971-81. doi:10.1111/pme.12107. READ

Full-Day Convenings

OCTOBER 2015

- ▶ Safer prescribing intensive training
- ▶ Co-prescribing naloxone: review of the evidence, and practical tips
- ▶ Meet with faculty: coaching in developing policies and procedures, and getting buy-in; setting up opioid review committees; developing addiction and behavioral medicine curricula; quality improvement 101 and developing action plans
- ▶ Group sharing of strategies and challenges

MARCH 2016

- ▶ What have we learned: new ways to think about pain and addiction (*Dr. Kelly Pfeifer, CHCF*)
- ▶ Residency program updates (*Pecha Kucha: sharing what we learned through rapid-fire images and storytelling*)
- ▶ Buprenorphine management of pain (*Dr. Howard Kornfeld, Recovery Without Walls and the Highland Hospital Functional Restoration Clinic*)
- ▶ Physical therapy and occupational therapy approaches to pain management (*Jen Carton-Wade, OT, Laguna Honda Hospital*)
- ▶ Action planning: continuing progress when the action group is complete

Appendix A. Resource Links

This list of sample guidelines, flowcharts, and assessment tools is not intended to be exhaustive. Rather, these resources were mentioned in discussions during the webinars. [▶ Click on the link to read or watch the video.](#)

General

- ▶ [How to Download Video Clips](#)

Addiction / Substance Use Disorder

- ▶ [Abramowitz, Sharone. "Addiction Medicine and Chronic Pain Curriculum." \(Internal Medicine Residency\), Highland Hospital, 2015.](#)
- ▶ [Abramowitz, Sharone. "Prescription Opiate Misuse: Resident Teaching 2014." Highland Hospital.](#)
- ▶ [O'Connor, Patrick, Julie G. Nyquist, and Thomas McLellan. "Integrating Addiction Medicine into Graduate Medical Education in Primary Care: The Time Has Come." *Annals of Internal Medicine* 154, no. 1 \(January 4, 2011\): 56-59.](#)
- ▶ ["Recommended Curriculum Guidelines for Family Medicine Residents: Substance Use Disorders." American Academy of Family Physicians, June 2011.](#)
- ▶ ["Curriculum on Addiction Medicine: SVCH Internal Medicine Residency Program." St. Vincent Charity Medical Center.](#)
- ▶ [Pade, Patricia A. et al. "Prescription Opioid Abuse, Chronic Pain, and Primary Care: A Co-Occurring Disorders Clinic in the Chronic Disease Model." *Journal of Substance Abuse Treatment* 43, no. 4 \(December 2012\): 446-50. doi:10.1016/j.jsat.2012.08.010.](#)

Buprenorphine

- ▶ [Gunderson, Erik W. et al. "Unobserved Versus Observed Office Buprenorphine/Naloxone Induction: A Pilot Randomized Clinical Trial." *Addictive Behaviors* 35, no. 5 \(May 2010\): 537-40. doi:10.1016/j.addbeh.2010.01.001.](#)
- ▶ [Cunningham, Chinazo O. et al. "A Comparison of Buprenorphine Induction Strategies: Patient-Centered Home-Based Inductions Versus Standard-of-Care Office-Based Inductions." *Journal of Substance Abuse Treatment* 40, no. 4. \(June 2011\): 349-56. doi:10.1016/j.jsat.2010.12.002.](#)
- ▶ [Lee, Joshua D. et al. "Home Buprenorphine/Naloxone Induction in Primary Care." *Journal of General Internal Medicine* 24, no. 2 \(February 2009\): 226-32. doi:10.1007/s11606-008-0866-8.](#)

Clinical Education Tools

- ▶ [Opioid Dose Calculator](#)
- ▶ [Pathways to Safer Opioid Use: Health.gov's compelling interactive educational tool for doctors, nurses, and pharmacists, with brief videos and decision points](#)
- ▶ [Educational presentations from the CDC](#)
- ▶ [Oregon Pain Guidance: tools for providers and patients](#)
- ▶ ["Primary Care Guidelines Flowchart"](#)
- ▶ ["Interagency Guidelines on Prescribing Opioids for Pain" from the Washington State Agency Medical Directors' Group](#)
- ▶ [Physicians for Responsible Opioid Prescribing: educational videos, guidelines, news, and advocacy](#)
- ▶ ["Educating Prescribers About Naloxone to Prevent Opioid Deaths:" patient and provider educational materials from CHCF](#)
- ▶ ["The Art \(and Very Little Science\) of Tapering Opioid Medications:" video of a lecture by Andrea Rubinstein, pain management specialist, Kaiser](#)

Coalition Member Websites (selected)

- ▶ [RxSafe Marin, with ▶ \[LiveStories report card\]\(#\)](#)
- ▶ [Safe Med LA](#)
- ▶ [San Diego Safe Prescribing](#)

Coalition Tools

- ▶ [Awareness dates: These national "awareness" days, weeks, and months are opportunities to promote issues and events.](#)
- ▶ [An Action Guide for Management of Opioid Dependence: Next Steps for Payers and Policymakers from the New England Comparative Effectiveness Public Advisory Council](#)
- ▶ ["Prevention Tools" \(MassTAPP\)](#)
- ▶ ["Safe Pain Medicine Prescribing in Emergency Departments \(L.A.\)"](#)

- ▶ "Opioid Overdose Prevention Toolkit" (SAMHSA)
- ▶ "Prescription Drug Community Action Kit" from the National Safety Coalition

Government Resources

- ▶ CDC Prescription Drug Overdose website: resources, publications, educational materials for the public and providers

Health Plans and Health Systems

- ▶ *The Prescription Opioid Epidemic: An Evidence-Based Approach.* Johns Hopkins School of Public Health. 2015.
- ▶ "Managing Pain Safely (MPS)," Partnership HealthPlan of California's initiative

Journalism

- ▶ "Dying to Be Free: There Is a Treatment for Heroin Addiction That Actually Works. Why Aren't We Using It?" Jason Cherkis. *Huffington Post*, January 28, 2015.
- ▶ "Chasing Heroin": *Frontline* series with background information on the opioid epidemic

Marijuana

- ▶ "Research Report Series: Marijuana." National Institute on Drug Abuse. September 2015.
- ▶ "Public Policy Statement on Marijuana, Cannabinoids and Legalization." American Society of Addiction Medicine. September 21, 2015.

Obama Administration's Priority Areas to Address Prescription Opioid Abuse Epidemic

1. Safe prescribing training and educational resources

Sample guidelines

- ▶ Medical Board of California guidelines
- ▶ Oregon Pain Guidance's excellent toolkits that include resources for difficult conversations, nonopioid options, group and behavioral visits, tapering, risk screening tools, etc.
- ▶ Partnership HealthPlan of California's sample guidelines for clinics, EDs, pharmacies, and dental offices

Residency curriculum resources

- ▶ Curated educational resources from Oregon (videos, PowerPoints, websites, tools)

General resources

- ▶ CURES registration
- ▶ OpioidCalc opioid equivalent calculator: Free smartphone app (iOS or Android)
- ▶ Substance Use Screening and Assessment Instruments Database
- ▶ Urine drug screenings FAQ (pages 44-46)

2. Increase use of Naloxone

- ▶ Patient education resource
- ▶ Provider education resource

3. Expanding the use of medication-assisted treatment (MAT)

- ▶ "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction" (SAMHSA)
- ▶ "Buprenorphine Training for Physicians" (SAMHSA)
- ▶ Providers' Clinical Support System for Opioid Therapies (PCSS-O)

Appendix B. Using the National Safety Council's Community Action Kit

Using the Community Action Kit	Who Should Be Involved	Goals	Taking Action	Measuring Success
<p>Engaging the Medical Community</p>	<p>public health, hospitals, physicians, dentists</p>	<p>reduce opioid prescriptions, improve pain and treatment</p>	<p>conduct hospital grand rounds, safer opioid prescriber training, academic detailing</p>	<p>number of prescribers trained, reduced number of prescriptions written</p>
<p>Safe Medication Disposal Guide</p>	<p>law enforcement, pharmacies, healthcare facilities, environmental groups</p>	<p>reduce amount of leftover drugs in community</p>	<p>start or expand permanent collection sites, host take back events</p>	<p>number of collection sites, number of pounds of unwanted drugs disposed</p>
<p>Preventing Overdose</p>	<p>law enforcement, first responders, medical community, parents, people in recovery</p>	<p>increase access to opioid antidote, reduce stigma</p>	<p>train first responders, drug users and family members in naloxone, change community policy, advocate for good samaritan law, if needed</p>	<p>number of naloxone kits distributed and people trained, overdose reversals</p>
<p>Public Education and Media</p>	<p>parents, schools, police, medical professionals, survivors</p>	<p>inform about dangers of opioid medications</p>	<p>hold overdose awareness events and school prevention activities, invite media, educate employers</p>	<p>number of events, number of attendees, number of media impressions</p>
<p>Early Intervention Treatment and Recovery</p>	<p>substance abuse professionals, medical providers, people in recovery, survivors, police, employers</p>	<p>increase awareness of treatment resources, expand access and availability of treatment, recovery resources - sober homes and recovery friendly jobs</p>	<p>build community resource network and/or referral systems, increase access to treatment</p>	<p>number of treatment providers, reduction in wait for treatment, increase resource guides and referrals</p>
<p>Advocating for Change</p>	<p>parents, community members, everyone, politicians, faith community</p>	<p>change laws, policies or how systems address the issue</p>	<p>actively engage community members in advocacy efforts</p>	<p>number of laws or systems changed</p>

Endnotes

1. Li-Hui Chen, Holly Hedegaard, and Margaret Warner, "QuickStats: Rates of Death from Drug Poisoning and Drug Poisoning Involving Opioid Analgesics — United States, 1999-2013," *Morbidity and Mortality Weekly Report* 64, no. 1 (January 16, 2015): 32, www.cdc.gov.
2. 2015 National Drug Threat Assessment Summary, US Drug Enforcement Administration (2015), www.dea.gov (PDF).
3. L. J. Paulozzi et al., "Vital Signs: Overdoses of Prescription Opioid Pain Relievers — United States, 1999-2008," *Morbidity and Mortality Weekly Report* 60, no. 43 (November 4, 2011): 1487-92, www.cdc.gov.
4. *The Prescription Opioid Epidemic: An Evidence-Based Approach*, Johns Hopkins Bloomberg School of Public Health (November 2015), www.jhsph.edu (PDF).
5. As of April 2016, the website of the American Pain Society indicates continuing grant funding from pharmaceutical companies. See www.americanpainsociety.org.
6. Samantha DuPont, Athan Bezaitis, and Murray Ross, "Stemming the Tide of Prescription Opioid Overuse, Misuse, and Abuse," *Health Affairs* blog, September 22, 2015, healthaffairs.org/blog.
7. Richard A. Mularski et al., "Measuring Pain as the 5th Vital Sign Does Not Improve Quality of Pain Management," *Journal of General Internal Medicine* 21, no. 6 (June 2006): 607-12, doi:10.1111/j.1525-1497.2006.00415.x.
8. M. K. Kotecha and B. D. Sites, "Pain Policy and Abuse of Prescription Opioids in the USA: A Cautionary Tale for Europe," *Anaesthesia* 68, no. 12 (December 2013): 1210-15, doi:10.1111/anae.12450.
9. Mark D. Sullivan et al., "Trends in Use of Opioids for Non-Cancer Pain Conditions 2000-2005 in Commercial and Medicaid Insurance Plans: The TROUP Study," *Pain* 138, no. 2 (August 31, 2008): 440-49, doi:10.1016/j.pain.2008.04.027.
10. Gary Franklin et al., "Opioid Use for Chronic Low Back Pain: A Prospective, Population-Based Study Among Injured Workers in WA State," *Clinical Journal of Pain* 25, no. 9 (November/December 2009): 743-51, doi:10.1097/AJP.0b013e3181b01710; Martin L. Rohling, Laurence M. Binder, and Jennifer Langhinrichsen-Rohling, "Money Matters: A Meta-Analytic Review of the Association Between Financial Compensation and the Experience and Treatment of Chronic Pain," *Health Psychology* 14, no. 6 (November 1995): 537-47, doi:10.1037/0278-6133.14.6.537; Bridget A. Martell et al., "Systematic Review: Opioid Treatment for Chronic Back Pain: Prevalence, Efficacy, and Association with Addiction," *Annals of Internal Medicine* 146, no. 2 (January 16, 2007): 116-27, doi:10.7326/0003-4819-146-2-200701160-00006.
11. Roger Chou et al., "Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain," *The Journal of Pain* 10, no. 2 (February 2009): 113-30, doi:10.1016/j.jpain.2008.10.008.
12. Roger Chou et al., "The Effectiveness and Risks of Long-Term Opioid Treatment of Chronic Pain [Evidence Report / Technology Assessment No. 218], Agency for Healthcare Research and Quality, September 2014, www.effectivehealthcare.ahrq.gov (PDF).
13. "CDC Guideline for Prescribing Opioids for Chronic Pain," CDC, last modified March 16, 2016, www.cdc.gov.
14. Deborah Dowell, Tamara M. Haegerich, and Roger Chou, "CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016," *Morbidity and Mortality Weekly Report* 65, no. 1 (March 18, 2016): 1-49, www.cdc.gov.
15. The 2016 CDC pain management guidelines recommend random urine drug screens, but their benefit should not be overstated: "No study evaluated the effectiveness of risk mitigation strategies (use of risk assessment instruments, opioid management plans, patient education, urine drug testing, use of PDMP data, use of monitoring instruments, more frequent monitoring intervals, pill counts, or use of abuse-deterrent formulations) for improving outcomes related to overdose, addiction, abuse, or misuse."
16. Matthew J. Bair and Erin E. Krebs, "Why Is Urine Drug Testing Not Used More Often in Practice?" *Pain Practice* 10, no. 6 (November/December 2010): 493-96, doi:10.1111/j.1533-2500.2010.00425.x.
17. *Prescription Opioid Epidemic*, Johns Hopkins Bloomberg.
18. Andrea Rubinstein, "The Art (and Very Little Science) of Tapering Opioid Medications," Partnership HealthPlan of California, December 6, 2014, www.youtube.com; "Tips on How to Safely Taper Patients Off of Prescription Opioids: An Interview with Mark Sullivan, MD, PhD," COPE, www.coperems.org.
19. Maya Vijayaraghavan et al., "Primary Care Providers' Judgments of Opioid Analgesic Misuse in a Community-Based Cohort of HIV-Infected Indigent Adults," *Journal of General Internal Medicine* 26, no. 4 (November 2010): 412-18, doi:10.1007/s11606-010-1555-y.
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21. Tamar Pincus et al., "A Systematic Review of Psychological Factors as Predictors of Chronicity/Disability in Prospective Cohorts of Low Back Pain," *Spine* 27, no. 5 (April 2002): E109-120, doi:10.1097/00007632-200203010-00017.
22. Aron J. Hall et al., "Patterns of Abuse Among Unintentional Pharmaceutical Overdose Fatalities," *JAMA* 300, no. 22 (2008): 2613-20, doi:10.1001/jama.2008.802; Kate M. Dunn et al., "Opioid Prescriptions for Chronic Pain and Overdose," *Annals of Internal Medicine* 152, no. 2 (2010): 85-92, doi:10.7326/0003-4819-152-2-201001190-00006.

23. Nicholas Henschke et al., "Behavioural Treatment for Chronic Low-Back Pain," *Cochrane Database of Systematic Reviews* 2005, Issue 7, Article No.: CD002014, doi:10.1002/14651858.CD002014.pub3.
24. Alexander Y. Walley et al., "Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis," *BMJ* 346 (January 31, 2013), doi:10.1136/bmj.f174.
25. E. Behar et al., "Primary Care Patient Experience with Naloxone Prescription," *Annals of Family Medicine* (forthcoming).
26. Barbara Masters and Mary Rainwater, *Recovery Within Reach: Medication-Assisted Treatment of Opioid Addiction Comes to Primary Care*, CHCF (March 2016), www.chcf.org.
27. "Buprenorphine Training for Physicians," SAMHSA, last modified July 7, 2016, www.samhsa.gov.
28. *A Guideline for the Clinical Management of Opioid Addiction*, Vancouver Coastal Health Authority and Providence Health Care (2015), www.vch.ca (PDF).
29. Emily Hurstak and Margot Kushel, *Pain Care on a New Track: Complementary Therapies in the Safety Net*, CHCF (July 2016), www.chcf.org.
30. "Creating a Culture of Safe Prescribing: CIN Action Group for Primary Care Residency Programs," CHCF, July 2016, www.chcf.org.