California Health Care Foundation

August 2017

Meeting Summary

Driving Toward Solutions: Providers Map Strategies to Reduce Opioid Deaths

Almost 2,000 Californians lost their lives to opioid-related overdoses in 2015, and solutions to this many-layered problem have been slow to spread.

To fast-track idea exchange about stopping overdose deaths, the California Health Care Foundation (CHCF) convened a meeting of physician group and health system leaders. The May 15, 2017 event was sponsored by Smart Care California in partnership with the UC Davis School of Medicine; California Departments of Justice, Health Care Services, and Public Health; CalPERS; Covered California; and CHCF. Bruce Spurlock, MD, executive director of Cynosure Health, and Kelly Pfeifer, MD, CHCF director of High Value Care, set the context for the session.

Pfeifer likened the slow spread of opioid overdose solutions to Atul Gawande's framing of health care's "slow ideas." Unlike the use of anesthetics in surgery, an innovation that caught on around the world in a matter of months, the achievement of handwashing and sterile surgical techniques took an entire generation. Unfortunately, reducing opioid deaths is more like the latter problem, Pfeifer cautioned. Whereas anesthetics brought immediate and substantial benefits to both physicians and patients, achieving clean surgical environments required tedious upfront work without instant results for anyone. Tackling a problem like this is an uphill battle, Pfeifer said. Reversing the epidemic will take coordinated work from health plans, providers, and policy-makers, and it will take time.

"Our goal for this convening is to cross-fertilize solutions that are *emergent*," emphasized Spurlock. "We want to come up with ideas that you can take back to your organizations and apply right away."

Dilemma for Prescribers

Scott Fishman, MD, chief of pain medicine at UC Davis, laid out some clinical, operational, and behavioral components of the prescription opioid problem. He cited Institute of Medicine data showing that 100 million Americans have chronic pain (not including children and people in acute pain or at the end of life), and that the US uses about 80% of the world's opioid supply. In other words, he said, in America we have more pain *and* excessive use of painkillers: *"How could both things be true?"*

Despite the lack of a rich database on chronic use of opioids, Fishman said, we know much more about the risks than we did a decade ago. Further, we are learning that the benefits are not as great as had been claimed, and that many people on opioids for chronic pain were not any better; in contrast, many experienced worsening pain over time. In prescribing, Fishman said, "We always have to consider the benefits and risks, but, as the data on benefits stay the same but risks increase, the balance point needs to shift toward the avoidance of risk."

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— Scott Fishman, MD

Primary care physicians, he said, are caught between the desire to reduce pain and the need to ameliorate risk. Frequently, specialty consultation is unavailable, and nonopioid pain treatments are difficult for patients to obtain. Unfortunately, Fishman added, physicians have not been trained to treat pain safely, and have relied on inadequate and inaccurate science that suggested these medications were safe in chronic pain management. "Now we know that is not true for most patients," he said. Further, methadone for pain treatment can be unpredictable; it accounts for 2% of prescriptions, but 30% of overdose deaths.

Fortunately, there is a large and growing body of guidelines and resources for prescribers (see box).

Guidelines and Resources for California Prescribers

- California Medical Board Guidelines for Prescribing Controlled Substances for Pain
- CDC Guideline for Prescribing Opioids for Chronic Pain
- Substance Abuse and Mental Health Services Administration (SAMHSA) Opioid Overdose Prevention Toolkit
- California Department of Public Health Opioid Prescribers Resource Sheet
- National Rx Drug Abuse & Heroin Summit
- University of New Mexico School of Medicine, partnering with Project ECHO, provides training in opioid addiction treatment at no cost.
- Boston University offers training titled Safe and Effective Opioid Prescribing for Chronic Pain, along with other resources for clinicians, at no cost.
- California Health Care Foundation resources on Opioid Safety
- Medication-assisted treatment: Providers' Clinical Support System for Medication Assisted Treatment (PCSS MAT) includes information on buprenorphine and free mentorship options; UCSF Warmline offers free consultation advice for providers by addiction specialists.

Fishman reviewed the basic advice offered to prescribers by major opioid prescribing guidelines: Get real informed consent; carefully consider new starts (starting people on long-term opioid treatment should be a rare occurrence); never use opioids as the mainstay of chronic pain treatment; treat acute pain with nonopioids where possible, and when opioids are needed, use low doses, short-acting pills, and short durations (three days or less). Rather than renewing automatically, see the patient and evaluate quickly, and consider that every additional day of opioid use increases the risk of long-term dependence. Review the patient's history of substance use, co-prescriptions, and alcohol; if patients are using opioids daily, co-prescribe naloxone.

He stressed the importance of collaboration across multiple health systems—including those who are competitors—working together rather than in silos.

The CURES Program

Lee Mosbrucker, chief of the Technology Support Bureau in the California Department of Justice, described planned enhancements to the Controlled Substance Utilization Review and Evaluation System (CURES) program, the DOJ's prescription drug monitoring system. All California pharmacies must submit data on all dispensed controlled substances within seven days of issue, and a new state law will require prescribers to check CURES before writing new prescriptions, and then every four months thereafter. To streamline access, the DOJ is working to create interoperability with electronic health records, allowing a single ID login. Other enhancements to increase usability are in development. Mosbrucker

also described the opportunity for electronic data exchange tools to search the database for alerts and high-risk use, and put the information in front of emergency physicians. A legislative proposal to enable this function has been introduced.

He cautioned that interpreting CURES information is not like a depression scale; it is more like reading an MRI. Every patient's situation is unique, and patterns that look concerning on the surface may have legitimate explanations. It is important to talk to the patient and assess the situation before acting on the information. In no case, he stressed, should a CURES report lead to firing a patient.

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The Medical Board of California also works to control opioid overuse. Board Member Michael Bishop, MD, described the Board's opioid-prescribing guidelines, as well as its outreach, education, and disciplinary efforts. Most of the problem prescribers, he said, are primary care physicians who have not been trained in the specifics of avoiding dependence and reducing overdoses. The Board, Bishop said, is aiming to work more actively to educate physicians.

Discussion: Efforts, Successes, Barriers

Small-group discussions followed these presentations, enabling participants to exchange information about problems, ideas for resolution, and new initiatives. Some are briefly described below.

Ideas and Initiatives

A number of opioid-focused programs are under way or are in start-up stages within health systems and provider organizations, including:

- **Integrated behavioral teams.** One large system established an integrated behavioral team at every patient care site, and tracks patients on opioids for chronic pain in an EPIC patient registry to ensure they receive recommended care.
- **Risk stratification.** Cedars-Sinai built electronic decision supports, such as alerts and standard templates, into its EPIC health record, allowing risk stratification of patients and referrals to multimodal treatments. The amount of work discouraged some providers from using the program, so more effort is going into promoting adoption.
- **Pre-surgery tapering.** Cedars-Sinai surgeons noted that most patients were on high levels of opioids prior to spinal surgery, and many had poor surgical outcomes. Realizing that many patients experience hyperalgesia, where high opioid doses can worsen pain, the program used other pain modalities and tapered patients to lower opioid doses prior to surgery. Some of these patients improved so much that they no longer needed surgery, and those who had surgery experienced better outcomes.
- **Culture change.** ED physicians at San Mateo Medical Center led an effort to change the culture to ensure that patients presenting for refills in the ED were instead connected with primary care providers.
- **Education.** Kaiser Permanente reinforces prescribing guidelines by requiring all family medicine and internal medicine physicians to attend a 6-hour educational program focused on treating patients with chronic pain and those

Provider group database to assist prescribers

Using CDC guidelines as a base, a 170-member medical group created an organization-wide database on two measures—numbers of high-dosage patients and length of time on opioids before a patient/physician visit. Data comes from the health plans' pharmacy records, as well as the EMR. About 60 percent of patients are captured.

These data identified that large numbers of patients are on high doses of opioids, and some stay on opioids without seeing a physician for over a year. The vast majority of prescriptions come through the group's PCPs. The group now makes PCP education a priority and shows physicians their individual data reports, compared to their peers. A pain management expert has been hired to help manage the high-dose patients.

seeking opioids. Orthopedists, who are the largest prescribers of opioids in the system, will soon begin receiving similar training. Kaiser also requires patient education before starting any member on opioid treatment.

- **County-wide task force.** The San Francisco Department of Public Health, partnering with the local Medi-Cal health plan, created a county-wide task force to develop community prescribing policies, offer provider and patient education, and improve access to opioid addiction treatment. Its services include educational conferences and materials, prescribing guidelines, and clinic peer review committees to help providers make more rational prescribing choices. The county primary care system also created a pain registry that is auto-populated when anyone receives a pain diagnosis, which helps support patients receiving recommended interventions.
- **ED physicians leading change.** As part of the East Bay Safe Prescribing Coalition, John Muir Health emergency physicians have been active on several fronts: adopting guidelines, promoting non-opioid treatment options, and providing scripts with talking points for physicians to use in counseling patients about alternative choices to opioids. They also encourage oral medications instead of IV, lower numbers of pills, and the use of ketamine for pain control.

Problems and Complications

The discussions uncovered a variety of barriers and complications that must be addressed, including:

- Hiring a pain management specialist can cause other physicians to turn over their pain patients to that person rather than becoming comfortable managing patients who need opioid tapers themselves. Dr. Fishman described a new Train The Trainer program that works with primary care prescribers who can help all the clinicians in their primary care community to provide safe and effective pain care.
- Physicians outside of a large or integrated system often lack the support needed to manage opioid use and overuse.
- Naloxone prescribing has been slow to spread; pharmacies do not yet routinely stock it, and copayment amounts can be prohibitive.
- Peer support for high prescribers can feel like a punitive peer review if not handled well.
- Dentists, orthopedists, and others may start opioid prescriptions, but refills fall to PCPs who may be unequipped to manage them.
- Alternative therapies for pain, as well as medication-assisted treatment, have not been well promoted by physicians or covered by health plans.
- Many participants were concerned that their organizations may not be ready to comply with the CURES requirements. Separate sign-on protocols make it difficult for clinicians to access the database, and some physicians are unclear on how to use the information to help patients. Further, there is concern that CURES data will cause physicians to fire patients, either due to misunderstanding the data without confirming what happened with the patient, or in lieu of working with patients to get them into addiction treatment when indicated.
- Dentists and orthopedists often prescribe opioids for their patients, but don't use guidelines or work to monitor and control misuse.

Treating Substance Use Disorder (SUD)

Leaders exchanged strategies for working with patients addicted to opioids. Some of their ideas and initiatives are briefly described here:

- San Mateo County, using a hub-and-spoke model, works with four affiliated clinics to start patients on buprenorphine in an outpatient setting. The program is integrated with behavioral health and medication management specialists. Patients are then referred back to primary care when stable.
- San Joaquin General Hospital is working to reduce the stigma of SUD. Several family medicine physicians have waivers to dispense buprenorphine, and there are discussions around starting a buprenorphine induction clinic.
- Sutter Health uses the Quartet program to support collaboration between primary care and mental health providers. They also use

mental health telemedicine technology to link ED and clinic patients with a psychologist very quickly.

- Riverside University Health System is setting up a program where a board-certified psychiatrist is available via telemedicine within one hour if a patient needs SUD treatment. An outside organization sources the psychiatrists. Riverside plans to deploy the program across all 24 of its facilities.

A discussion of the inadequate supply of addiction specialists inspired a variety of ideas:

- Do more buprenorphine inductions for patients with addiction while they are inpatients, working with hospitalists to demonstrate that it is not necessarily complicated or difficult.
- Develop opportunities for pharmacists to work with prescribers and help patients taper to safer doses.
- Make more use of telemedicine, hub-and-spoke models, and group visits. Communicate to other clinicians how these methods can be operationalized.
- Create more addiction medicine fellowships (to date, California has programs sponsored by the Betty Ford Center, Stanford University, and San Francisco General Hospital).
- As was done with HIV treatment, make preventing and treating SUD a part of the core curriculum for primary care in medical schools and residency.

Participants also spoke of the need to change the expectations in pain management not only in physicians but also in patients. They suggested the use of educational videos, written materials, online personal action plans, and peer counselor networks. One health care leader suggested that primary care clinicians switch from the standard 0-10 pain scale to a functional measure based on what the patient wants to be able to do—"I want to be able to play catch with my grandson." This, he said, would enable patients to feel they are helping themselves.

A "Slow Idea" Moves Ahead

In Pfeifer's closing comments, she reiterated that significant progress in reducing opioid-related deaths and dependency is likely to be one of health care's "slow ideas." "This is going to be as hard as universal acceptance of hand-washing in surgical suites," she cautioned. "But that doesn't mean we can't make it happen the same way, using multiple levers at once: education, regulation, system changes, and measurement."

The day's convening, she noted, pointed to areas in which providers, systems, and health plans can make progress:

- Develop a clear vision and call to action
- Build partnerships, inside and outside of health care
- Collect and use data to monitor progress

In particular, Pfeifer said, we need to find ways to support primary care prescribers through team-based models that share the care, especially as more clinicians take on managing patients with addiction. "Helping people move from chaotic lives to recovery is one of the most satisfying opportunities in medicine—but it is not possible for most doctors to take this on unless support staff provide wraparound support."

Tackling the opioid epidemic, Pfeifer concluded, "will take all of us together: policymakers, plans, providers, patients. We are only at the beginning. What happened here—competitors gathering to share ideas and work on a problem together—will help us get where we need to go."

New Grant Opportunity to Increase MAT Access

California received $89 million to support increased access to medication-assisted treatment in California. The grant focused on using the hub-and-spoke model, where opioid treatment programs (hubs) manage complex patients, and support primary care practices (spokes) to manage patients once they are stable on maintenance treatment.

More information is available here.

About the Author

Susan Anthony is a health care editor and writer.

About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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