



CALIFORNIA HEALTHCARE FOUNDATION



Striking a Balance: Safety-Net Leaders Explore Solutions to the Prescription Painkiller Epidemic

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About the Foundation

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

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.



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Executive Summary

Clinics and health plans serving low-income populations face a tremendous challenge — how to provide compassionate care for patients dependent on high-dose opioids, in the face of a growing epidemic of narcotic addiction and overdose deaths. The California HealthCare Foundation's California Improvement Network, a community of organizations engaged in improving health care delivery, convened leaders from health plans, community clinics, and government agencies on November 5, 2014. The goal of this convening, "Management of High-Dose Opioids in the Safety Net," was to devise a menu of approaches appropriate for California clinics and Medi-Cal health plans.

The group talked about the current challenges facing providers caring for patients on high-dose opioids and about promising models for treatment, and converged on a set of approaches for organizations focused on low-income patients:

- ▶ Create broad community coalitions.
- ▶ Build a culture of safe prescribing by establishing consistent clinical and operational practices.
- ▶ Offer provider training programs and resources.
- ▶ Create multidisciplinary teams to work with patients on high-dose opioids or with complex conditions.
- ▶ Spread medication-assisted addiction treatment options.
- ▶ Deploy utilization and reporting tools to support safer prescribing.
- ▶ Explore payment reform to support integrated care.
- ▶ Develop and report outcome measures.

Convening participants agreed that because the epidemic of opioid overdose has many causes, its eradication will take the coordinated efforts of players from across the health care sector and from the community.

Introduction

The California HealthCare Foundation's California Improvement Network, a community of health care organizations engaged in improving care delivery, invited a group of clinical experts to review the factors leading to the epidemic of opioid-related overdose

deaths in California, and to explore opportunities to address the problem in the safety net. The convening focused specifically on high-dose opioid prescribing for chronic noncancer pain, and aimed to develop a menu of best practices and promising models that could be adapted for spread in California clinics and Medi-Cal health plans.

Participants included representatives from health plans, community clinics, government agencies, and integrated systems (see Appendix A for a full participant list). Kelly Pfeifer, MD, director of the Better Chronic Disease Care program at the California HealthCare Foundation (CHCF), launched the convening with a question to the group: What can be done to improve the lives of patients on high-dose opioids, while following safe prescribing practices, in settings with limited resources?

This report describes the topics discussed over the course of the day: the problem of high-dose opioid use, the challenges involved in changing prescribing practices, and promising models that could be piloted and spread in organizations caring for low-income populations.

Background: How Did We Get Here?

Jane took high-dose opioids for years, yet always rated her back pain as 7 out of 10, and I continued the meds at her insistence. Several years after leaving the practice, I saw Jane's brother, who told me: "Doc, my sister was so upset when you left — her new doctor made her wean off the drugs. No offense, but she now says your leaving was the best thing that could have happened to her. She lost 50 pounds, looks 10 years younger, and her pain is gone."

When I was in training, I was taught that when in doubt, increase the dose of meds until the pain is controlled. Now many pain patients are taking the equivalent of 20 Vicodin a day or more, but their pain is the same or worse. At the same time, they can't imagine a life without the meds. With the best of intentions, we have created this situation: steadily increasing rates of dysfunction, addiction, and overdose deaths, all with a high cost to our society and to our health care system.

—Kelly Pfeifer, MD, director, Better Chronic Disease Care, California HealthCare Foundation

A Shift in Prescribing Culture

Many of the providers at the convening started their practices in the 1990s, when a movement was growing to address what was considered an epidemic of undertreated pain. Clinicians were encouraged to routinely screen for pain, which became known as a “fifth vital sign,”¹ and were sued for ignoring pain.² Medical literature, with substantial financial backing from the pharmaceutical industry,³ encouraged prescribers to increase doses of narcotic painkillers, or opioids, with no maximum dose. Well-meaning providers were falsely reassured by studies showing low rates of addiction,⁴ and daily doses grew to levels previously seen only in end-of-life care.

Fast-forward to the present. The opioid hydrocodone, the main ingredient in Vicodin, has become the single most prescribed drug in the US.⁵ Twenty percent of patients who are chronic opioid users receive extremely high doses — 100 mg of morphine equivalent dose (MED) or more, equivalent to 20 Vicodin a day — and these patients account for 80% of prescription opioid overdoses.⁶ Low-income populations are at particular risk: a Washington State study found the chance of dying of an opioid overdose was almost six times more likely for people on Medicaid than for the general population.⁷

New Understanding of Risk and Harm

“When an antibiotic doesn’t work, we don’t just double the dose,” said Amit Shah, MD, of CareOregon, “yet we somehow have convinced ourselves that when people are still in pain, we just need to push the dose higher.”

Participants discussed recent evidence casting doubt on the effectiveness of high-dose opioids for chronic non-cancer pain,^{8,9} especially for common conditions such as low-back pain, chronic headache, and fibromyalgia.^{10,11} They talked about how patients’ pain scores tend to stay the same, no matter how high the dose — an impression that was confirmed by a 2013 study finding that self-reported pain scores stayed consistent over time, despite doses increasing up to 1,400% over seven years.¹²

At the same time, evidence is accumulating to show that liberal opioid prescribing for widespread indications and at high doses is doing substantial harm to individuals and to the general public:

- ▶ Opioids can increase sensitivity to pain and worsen patients’ experience of pain, within as little as one month of treatment.^{13,14}
- ▶ More than 75% of patients on who are chronic opioid users have some form of sleep apnea,¹⁵ and more than 70% of men on high-dose opioids have low testosterone.¹⁶
- ▶ Methadone, an opioid used for both pain and for treatment of addiction, can lead to potentially fatal heart problems. (Of all opioid-related deaths, 30% involved methadone.¹⁷)
- ▶ Between 1997 and 2007, prescribed opioids increased by 600%, and opioid-related deaths increased by 300%.¹⁸
- ▶ For every prescription painkiller overdose death, there are an additional 10 substance abuse treatment admissions, 32 emergency department (ED) visits, 130 people who abuse or are dependent on opioids, and 825 people who report nonmedical use of opioids.¹⁹
- ▶ One in seven US teens admits to abusing opioid medications.²⁰

Participants discussed the substantial economic cost of the rise in use of prescribed opioids. Increased costs to the health care sector, workplaces, and the criminal justice system from US opioid overuse are estimated to have exceeded \$55 billion in 2007 alone, with opioid misuse and recreational use costing health insurers up to \$72.5 billion a year.²¹

Participants also described the toll the opioid boom has taken on health care professionals: Staff burn-out has become a persistent problem at organizations that treat large numbers of pain patients. “Until we implemented our new pain programs, we couldn’t retain providers — one year we lost three doctors in 12 months — most of them stating it was the chaotic system and the demands of pain patients that made them leave,” said Nurit Licht, MD, chief medical officer at Petaluma Health Center.

Walking the Tightrope — Treating Pain Without Causing Harm

Convening participants discussed the challenge faced by clinicians — despite the widespread use of prescribed opioids, chronic pain remains a serious issue, afflicting more US adults than the total affected by heart disease, cancer, and diabetes combined.²² Compared to the general population, people living in poverty face more risk factors for chronic pain: higher rates of childhood trauma and community violence, unsafe environments that are not conducive to physical activity, and higher rates of obesity.

Clinic leaders at the convening described the particular challenges of treating low-income patients with chronic pain: Common alternatives to prescription opioids, such as physical therapy, complementary medicine, acupuncture, chiropractic care, and massage, are difficult to access for Medi-Cal patients. The pressure remains high for clinicians to prescribe opioids when no other choices are available.

Although convening participants agreed with the goal of decreasing opioids, they were also concerned about unintended consequences when clinicians are pressured to decrease prescribing. Forcing opioid-dependent patients to leave a practice can lead to those patients seeking illegally sold prescription opioids or to a much cheaper option — heroin. West Virginia is a painful example. When law enforcement cracked down on “pill mills” — practices with high rates of opioid prescriptions — the drop in the prescription opioid death rate was matched by a tripling of heroin deaths between 2007 and 2012.²³

“The medical community has created a population of opioid refugees,” commented Bill Hunter, MD, medical director of Open Door Community Health Centers, a community clinic system serving two of California’s most isolated, rural counties. “We have patients who took these drugs on doctor’s orders, and then when that doctor moves, no one wants to take them on.” These patients find themselves unable to function without opioids but also unable to find a physician to help them stop.

Some people . . . have used for so long and so much that they have broken the part of their brain that makes dopamine. If you have broken [that] part of the brain . . . you’re always going to need dopamine replacement. If your pancreas gets broken and you don’t make insulin, we give people insulin all day long to replace that. If they go out and eat six Krispy Kremes and show up to the office with a blood sugar of 400, we don’t fire them. But if somebody doesn’t have dopamine, and we are not replacing the dopamine, and they take two Norco they bought from a friend, they get fired from a primary care practice. . . . [T]his is a chronic neurobiologic disease. If we catch them early, we will be able to stabilize them and get these parts of the brain to heal. . . .”²⁴

—Corey Waller, MD, a nationally known neurobiologist and pain specialist at the Center for Integrated Medicine in Michigan, during a lecture at Maine Quality Counts’ Community Care Team 2013 Summit

The Challenge for Safety-Net Providers

Because long-term use of high-dose opioids changes brain neurochemistry, tapering patients from high doses requires patience and skill on the part of the prescriber. Andrea Rubinstein, MD, chief of the department of pain management at Kaiser Permanente Santa Rosa, described her approach to tapering patients from high doses of opioids as “art and very little science.” She shared that with support from a multidisciplinary team, 90% of people on high-dose opioids with chronic pain can be successfully tapered to lower doses. Rubinstein shared: “People don’t want to be on these meds — their whole life is controlled by waiting for the next dose. I find that people are desperate to have their life back, but don’t know how to do it on their own.”

While tapering patients from high-dose opioids can lower patients’ death rates and pain scores, and improve their function and their overall quality of life,^{25,26} it is challenging for primary care providers to find the time and support to do it well. The studies showing good results used multidisciplinary teams with medical, mental health, and substance use expertise, an approach that is resource-intensive, and that is not readily available in most community clinic settings. Participants expressed

frustration that low-income patients do not have access to therapies that can help them cope with the process of tapering to lower doses, such as mindfulness training, cognitive behavioral therapy, physical therapy, acupuncture, or chiropractic care.

There is not a clear consensus on which patients can be tapered off completely and which patients will need long-term opioid replacement because their brain neurochemistry has been permanently altered. Convening participants had a vigorous debate about the use of buprenorphine (brand name Subutex or Suboxone), a medication approved for short- and long-term treatment of opioid use disorder. Many participants argued that buprenorphine is a safer choice than other opioids for patients with chronic pain and opioid dependence, even if they don't meet criteria for

opioid use disorder. Buprenorphine can better control pain, improve function, and decrease risk of accidental overdose. Rubinstein often offers buprenorphine to opioid-dependent patients for pain control, even in the absence of addiction. She explained: "My patients on buprenorphine find they no longer have daily pain that comes from constantly being in partial withdrawal, while waiting for the time to take the next pill. Patients say they feel 'normal' for the first time in years."

Other participants expressed concern that if buprenorphine is seen as a panacea and is overused, then the solution to one problem may create another. Participants were particularly concerned that buprenorphine not be considered first-line treatment for pain — rather, it should be reserved for patients who are tolerant to high doses of opioids already.

Community Impact in Portland, Oregon

Amit Shah, MD, medical director at **CareOregon**, an Oregon Medicaid plan, was invited to the convening to discuss a citywide initiative he led while medical director of the public health system. Portland's alarmingly high opioid-related death rate was the catalyst for him to launch a safe-prescribing initiative that spread from public health clinics to safety-net providers across the city.

The county medical system created a set of best practices in three areas: (1) identifying patients with addiction, and coordinating their referral to treatment; (2) identifying patients with 1 of 12 contraindications to opioids, and tapering doses down or off altogether; and (3) lowering all high doses to a safer dose. The rapid changes in prescribing practice at the public health clinics led to dramatic improvements across the city. Although the pace of change was criticized, the number of patients who are chronic opioid users in the public health system decreased by 50% over two years. Shah said that a key lesson of this experience was the need to include other community clinics, emergency departments, and behavioral health providers in the planning process. (See Appendix D for more details about the Portland strategy.)

Independent of this initiative, **Central City Concern**, a Portland clinic that serves the homeless population, developed a rich set of nonopioid treatment options for patients with chronic pain, such as drop-in acupuncture visits, movement classes, and occupational therapy. All chronic pain patients are evaluated regularly and placed in categories — low-, medium-, and high-risk — that dictate their treatment plan:

Low-risk patients, with good self-management skills and social support, see their provider and receive a urine drug screen every three months. Once a year, these patients sit down with a provider to review their pain agreement, a document explaining the risks of opioid treatment and the policies of the clinic that ensure safe prescribing. Low-risk patients also have an annual pill count and review of their file in the state prescription drug database, which contains records of all opioids and other controlled medications that were filled by each patient.

Medium-risk patients, who have low self-management skills, little social support, or low activity levels, receive a behavioral health assessment and treatment, see their doctor monthly, participate in physical activity groups, and are monitored more closely for substance use.

High-risk patients, who are in the early stages of recovery from addiction, or who have had a brief relapse, are required to participate in an intensive educational program on relapse prevention and coping skills, to identify and maintain progress toward personal goals, to engage in behavioral health treatment, and to reduce their opioid dose. If they do not participate, opioids are not prescribed for pain, but buprenorphine treatment is available and encouraged.

Central City Concern providers treat substance use as a chronic disease, and they deliver compassionate patient-centered care with firm limits — if there is active substance use, they do not feed the substance use with prescribed narcotics. Instead, identification of substance use leads to a conversation and immediate connection to on-site resources for counseling, complementary therapies, and buprenorphine when needed.²⁷

Emerging Practices in the Field: Whose Example Can We Follow?

At the expert convening, participants identified promising programs that are already in place — inside and outside of the safety net, and inside and outside of California.

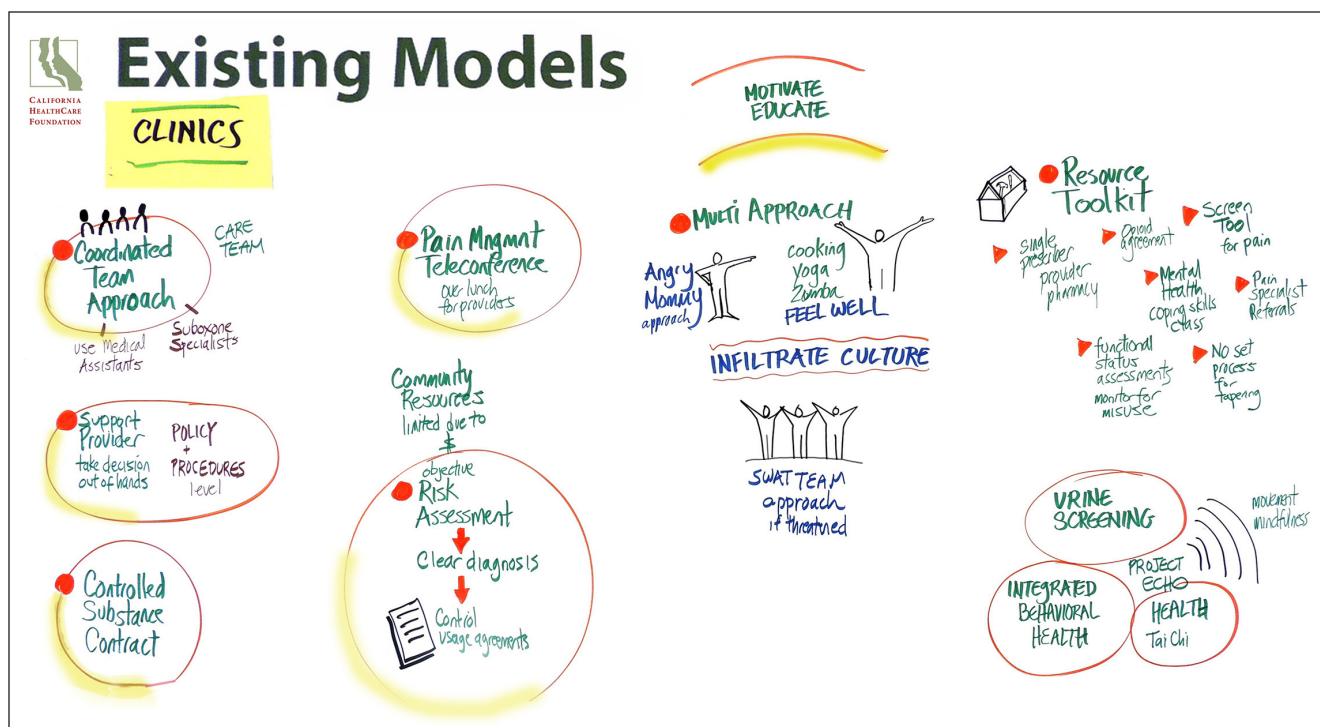
Team-Based Whole Person Care

Whole person care refers to coordinated patient care that addresses physical, emotional, social, and spiritual wellness, using a team of medical, behavioral health, and complementary care providers. Effective whole person approaches can address the complexity of pain by (1) identifying and treating depression, anxiety, and other mental health disorders that can exacerbate pain; (2) teaching patients effective coping strategies through mindfulness training and group classes; and (3) offering nonopioid pain treatments including medications, alternative therapies (such as acupuncture or movement therapy), and coaching to encourage patients to regain strength, flexibility, and functional independence.

The **Inland Empire Health Plan**, which covers San Bernardino and Riverside Counties, was the first Medi-Cal plan in the state to fully integrate behavioral and physical health services. The plan is piloting two new integrated pain programs:

- ▶ Patients seeking spinal cord stimulators are evaluated by a multidisciplinary team, including a psychiatrist, physical therapist, and a physiatrist/pain specialist, and receive a comprehensive set of recommendations for therapy.
- ▶ Patients with potential addiction in a particular region are seen by an integrated team to coordinate prescription issues, addiction treatment, mental health care, and other interventions focused on overall wellness.

As one step toward whole person care for a set of their chronic pain patients, the **Central California Alliance for Health**, a Medi-Cal plan covering Merced, Monterey, and Santa Cruz Counties, launched a pilot program to test a new acupuncture benefit with a population on high-dose opiates for chronic noncancer pain, and to evaluate the impact of the acupuncture treatment on ED and opioid use. An analysis of the first five months of the program found that those on high-dose opioids often missed appointments, but a significant number of members have reported improvement in pain and have been able to decrease opioid doses while undergoing acupuncture



Provided by Kayla Kirsh, Leapfrog Consulting

treatment. A second pilot program, which started in late 2014, evaluates the impact of primary care provider (PCP) referrals to a pain specialist with expertise in medication management, procedural interventions, and complementary and alternative treatment. An analysis of the first 70 referred members showed a 25% decrease in overall opioid pain medication use over the first three months following their initial visits.²⁸

Other examples of integrating behavioral and medical services include:

- **Rancho Los Amigos**, a large acute and rehabilitation county hospital in Los Angeles serving 4,000 inpatients and 71,000 outpatients a year, requires all patients who are chronic opioid users to be reviewed by a team, including specialists from physical therapy, occupational therapy, social work, and psychiatry.

Chronic Pain Clinic at Kaiser Permanente Santa Rosa

At a **Kaiser Permanente** clinic in Santa Rosa, whole person care is used to taper patients off of high doses of opioids. As chief of the department of pain medicine, Andrea Rubinstein, MD, leads a team that includes a physical therapist, social worker, nurse, psychologist, and acupuncturist, who work together to develop a comprehensive plan to taper patients to a lower dose of opioids, or off of them completely.

Rather than focus solely on the risk of addiction, the team helps patients see the many other ways their lives are limited by opioid use. After an initial evaluation, patients go through an education program to understand the risks associated with continuing opioids and the potential benefits of tapering. Patients are taught how opioids can worsen pain through hyperalgesia — an increased sensitivity to pain resulting from chronic use of the drugs. Dr. Rubinstein stated that 90% of patients who have gone through these sessions agree to participate and are successful at tapering to lower doses — and around 5% are able to taper off narcotics altogether.

Rubinstein developed a simple interactive calculator that enables providers to develop a tapering plan (see Appendix B for a link to the calculator).

She has a treasure trove of success stories of patients who have improved their lives after lowering doses. These patients experience less pain, function better, are less anxious, and have fewer depression symptoms.

These specialists meet with PCPs and attend clinic to discuss care management directly with the patient and the provider.

- **Riverside County Department of Ambulatory Care** is a county delivery system that offers a behavioral health coping skills group to its patients on high-dose opioids. Group participants receive behavioral health coaching and peer support.

Some health plans are launching their own multidisciplinary clinics. For example, **CareOregon**, a Medicaid plan in Oregon, created health plan-sponsored clinics, such as the North Coast Pain Clinic, which is run by a psychologist with special training in chronic pain. Patients at this clinic undergo a thorough assessment during which their medications are reviewed, and recommendations are made for treatment. The clinic offers classes in relaxation, movement, coping, and stress management techniques, as well as support groups and assistance in setting and achieving health goals.

Challenges

The type of clinic led by Rubinstein at Kaiser Permanente can be difficult to replicate in the safety net, largely due to financial constraints. In Medi-Cal, each of the services that are seamlessly linked in Rubinstein's clinic — mental health, addiction treatment, and medical care — are paid for by different programs, and are rarely found in the same location.

Culture of Safe Prescribing

Changing habits and culture within an organization must involve staff at all levels and is hard work. Getting providers to agree about how patients should be treated, and then institutionalizing best practices into all patient touches, from the appointment-making process to the check-in procedure, from back-office protocols to provider visits, can improve safety, quality, and satisfaction for patients, staff, and clinicians. The key to developing a culture of safe prescribing is maintaining consistent clinical and operational practices.

Petaluma Health Center (PHC), a community clinic serving over 23,000 patients, underwent a significant culture change over the last 15 years. In 2000, the clinic had a reputation for liberal prescribing practices, and patients would travel from several counties away to receive opioids. Prescribers were inconsistent in their approach, leading patients to move from stricter providers to



Provided by Kayla Kirsh, Leapfrog Consulting

more lenient ones, only to have the latter burn out and leave the clinic. Clinic staff were overwhelmed with the large volume of refill requests on Friday afternoons, and patients complained about poor service, long wait times for appointments, and unfair, inconsistent treatment.

Over the years, the clinic developed a compassionate but consistent approach to pain management. Clinic leaders standardized treatment guidelines and clinic protocols, and providers agreed to consistent practices. New team roles were developed. Receptionists were now responsible for screening new patients, and intake nurses were responsible for explaining the following practice rules to all new patients on high-dose opioids before their first visit:

- ▶ Medical records are required before prescriptions are written.
- ▶ The provider will work with the patient to develop a whole person treatment plan, which may include physical therapy, behavioral health coaching, or complementary therapy.
- ▶ Providers have the right to decide not to prescribe opioids, if the risks are greater than the benefits.

Patients understand the practice culture before they arrive, lessening surprises and angry altercations. Medical assistants identify when a patient is due for an updated pain management agreement, urine drug screen, or report from the Controlled Substance Utilization Review and Evaluation System (CURES, the state-run database of all controlled substances filled in California pharmacies). Providers agree to follow practice guidelines, including

a maximum opioid dose limit, ban on co-prescribing of benzodiazepines and opioids, and mandatory discontinuing of opioids in the presence of active substance use, with referral to treatment, including buprenorphine. Exceptions to these protocols require review by the opioid oversight committee or medical director. In addition, patients have access to wellness resources, including behavioral health services, acupuncture, exercise classes, and back pain classes. Providers receive periodic reports documenting the percentage of patients with treatment agreements, drug screens, and CURES reports, similar to reports on blood pressure and sugar control for diabetic populations.

The result of this change in prescribing culture has been dramatic: Provider turnover is minimal, patient satisfaction is high, and the Friday afternoon chaos is gone. PHC won awards for “best place to work” for the past five years. Registry reports confirm that best practices are followed: For example, 90% of patients have updated pain agreements, current CURES reports, and urine drug screens.

Similarly, the **Southern California Permanente Medical Group (SCPMG)** launched a major opioid prescribing initiative aimed at changing provider behavior to decrease overprescribing of opioids within the Kaiser Permanente system in Southern California. The program limits the new prescribing of high-street-value drugs, such as OxyContin, to specialists and suggests alternative drugs that have a lower risk of diversion, if a patient needs opioids. Patients receiving opioids at high doses, opioids in combination with benzodiazepines or carisoprodol (Soma), or any medication with high street value, are reviewed by clinician

teams who then work with primary care physicians to develop a safer care plan. SCPMG hosts education programs for providers focused on safe prescribing practices. As a result of these efforts, OxyContin prescriptions declined 80% over two years, and brand-named hydrocodone decreased by 95%.

Challenges

Changing provider behavior is difficult, and changing basic daily workflow in a clinic can be even harder. Convening participants discussed the many challenges faced by clinics across the state that are attempting to shift workplace culture: Doctors resist “cookbook medicine,” busy staff members resent additional duties, unions can make it difficult to change job descriptions and roles, and not all clinics have the capacity to run individual physician and team reports that can give real-time feedback on performance against standards. Clinics report investing time and energy into getting clinician agreement on protocols, only to have no one follow them. Strong, committed leadership and supporting leaders in the hard work of culture change were identified as key ingredients to success in this work.

Broad Community Coalitions

Creating a culture of safety across a community is just as important as building safe practices within an organization — without this community-wide coordination, patients struggling with addiction can jump from one system to another, receiving narcotics from multiple prescribers without the prescribers’ knowledge. Primary care providers, emergency physicians, dentists, and other specialists all contribute to the volume of narcotics in the community, and all need to be involved if the problem will be adequately addressed. Understanding that many factors contribute to opioid overuse, some organizations are spearheading community-wide initiatives with multiple stakeholders and organizations. Convening participants talked about initiatives that bring together health plans, emergency departments, substance use treatment centers, community providers, jails, and others to address the problem of opioid overuse as a community.

The effort in **Portland, Oregon**, is an example of a medical community agreeing to follow certain evidence-based best practices. The result? In Oregon’s Multnomah County system, the number of patients who are chronic opioid users decreased by 50% within two years of the launch of the program. (See page 5 for more information.)

A **workgroup of California state agencies**, including public health, justice, health care services, the medical board, and others, began meeting in early 2014 to identify strategies to decrease overdose rates across the state. This group was responsible for the December 2014 release of new medical board guidelines,²⁹ and is now creating a series of statewide heat maps showing profound differences in opioid prescription practices, treatment availability, and overdose death rates across the state. The state workgroup plans to use these heat maps and other public health data to identify high-impact areas in which to focus state and local multi-agency intervention efforts to decrease opioid overdose deaths.³⁰

The **Central California Alliance for Health** is also working on developing a community culture of safe prescribing, in close cooperation with local hospitals and the **Santa Cruz Health Improvement Partnership**, a coalition of public and private health care leaders, elected officials, and community stakeholders. The alliance supported the Monterey County Prescribe Safe Initiative in summer 2014, and similar plans are being made in Santa Cruz County. In partnership with community providers, the alliance is focused on decreasing opioid overprescribing in the emergency department (such as not refilling lost or stolen narcotic prescriptions), improving referral to substance use treatment, and encouraging more consistent use of CURES, to allow better identification of patients using multiple prescribers. The initiative was adopted by four hospitals in the Monterey region, and program leaders are currently reaching out to area primary care providers and pharmacies.

The alliance is also promoting opioid prescribing best practices in primary care through incentive payments, technical assistance and coaching, educational programs, and institutionalization of consistent practices for health plan review of medical records or discussion with the prescriber before approving the prescription to be filled.

Similarly, **San Francisco Health Plan (SFHP)** co-facilitates the San Francisco Safety Net Pain Management Workgroup, including providers from primary care, mental health, substance use, emergency medicine, and the county jail health department, to institutionalize best practices and encourage consistent prescribing practices across the county. Workgroup representatives gave presentations in EDs around the county to raise awareness and support for the effort. SFHP developed pain management guidelines, modeled after Portland’s, which were adopted by the San Francisco Health Network, the

county-run primary care system. The workgroup also organized medical education events on safe prescribing practices for prescribers and staff.

Partnership Health Plan, a Medi-Cal plan covering 14 counties in Northern California, created a systemwide initiative called Managing Pain Safely, which sponsored regional coalitions to work on local solutions to the opioid epidemic. The plan conducted a publicity campaign to promote new best-practice guidelines for primary care, pharmacy, and emergency departments. The plan sponsored educational conferences; instituted payment incentives for implementing best practices, including incentives for buprenorphine training and practice; and implemented policies that prohibit dose escalation without authorization and medical review.

Marin County, San Diego County, and New York City have also all launched successful county-wide initiatives. (See Appendix B for links to web resources for these programs.)

Challenges

Developing a community-wide, effective coalition is challenging. There is an art to bringing stakeholders to the table, hearing diverse viewpoints, and securing commitment from all parties to a common set of actions. Small counties often have big wins just from starting a conversation. For example, in a cross-disciplinary conversation, Marin County law enforcement officials learned that physicians never hear about arrest records, so they continue prescribing narcotics to patients arrested for selling drugs they prescribed. This conversation led to a new practice on the part of the county's police force of sending a letter to PCPs when their names are found on pill bottles secured during drug arrests. Solutions are more challenging in larger, more complicated counties such as Los Angeles.

Health Plan Utilization and Reporting Tools

To help curb overprescribing, health plans can exercise utilization controls, such as requiring a review for medical necessity prior to approval of high-dose narcotics, or reporting tools, such as identifying patients who are using multiple prescribers. Convening participants talked about the helpful “bad guy” role that health plans can



Provided by Kayla Kirsh, Leapfrog Consulting

play: It is sometimes easier for a PCP to say, “I’m sorry, but your health insurance does not cover this dose increase” instead of saying, “I don’t think it’s safe to increase your medicine.”

Health plans can create triggers requiring pharmacist interventions at certain dose thresholds or quantity limits, allowing case-by-case review and the ability to discuss the treatment plan with the prescriber. Pharmacist reviewers use protocols to identify when to make exceptions (e.g., end-of-life or acute post-surgical care) and when the prescriber should be called to negotiate alternatives. Health plans have access to rich pharmacy data and can analyze patterns of potential fraud or abuse, uncover unsafe drug combinations, or identify patients who are using multiple prescribers without their doctor’s knowledge. Examples of useful reports include:

- Top 100 patients in terms of total morphine equivalent dose, number of individual prescriptions, ED visits, or cost
- Patients receiving dangerous medication combinations (e.g., benzodiazepines and opioids, methadone and other opioids, and medications combining to equal a toxic dose of acetaminophen)
- Top prescribers, in terms of number of prescriptions or number of patients on high-dose opioids
- Patients engaging in polypharmacy (e.g., who have four or more prescribers, or using four or more pharmacies)

Plans have also implemented pharmacy or provider lock-in programs, which restrict a patient to a single pharmacy or prescriber when the data show use of four or more

prescribers or pharmacies. These lock-in programs prevent patients from obtaining unsafe combinations of opioids without the knowledge of their PCP (unless the patient chooses to pay cash instead of using the insurance card; prescriptions paid in cash are only visible in CURES.) By alerting prescribers and pharmacists to potential abuse of prescription drugs, lock-in programs have been shown to reduce costs for health plans by decreasing unnecessary emergency department visits (presumably because patients learn that prescriptions from these visits will not be covered), as well as avoiding the cost of prescriptions that are being sold instead of used as intended.³¹

The Central California Alliance for Health has multiple programs to support safe prescribing, including a pharmacy lock-in program triggered by the referring provider or data report. **CalOptima**, the Medi-Cal plan of Orange County, runs data reports to identify potential fraud on the part of patients or providers, and meets with State Health Care Services staff monthly to ensure that cases have been resolved through investigation. CalOptima also works with its Medicare/Medi-Cal members to limit them to a threshold of no more than 120 mg of morphine equivalent daily.

Some health plans generate and send reports to PCPs to alert them that their patients are receiving medications from multiple prescribers. **Inland Empire Health Plan** identifies high-risk patients in three categories: 180 or more short-acting pills per month, four or more pharmacies or two or more prescribers, or greater than 120 mg morphine equivalent per day. The plan requests patient/provider treatment agreements, progress notes, and a treatment plan. The plan pharmacist reviews these documents, contacts the provider to change the treatment plan if the regimen is found to be inappropriate, and implements a pharmacy or provider lock-in if needed.

Starting April 2015, **Partnership HealthPlan** will require that either prescribers refer certain high-risk patients (such as those on high dose, or with multiple prescribers) to a local opioid safety review committee, with recommendations sent to the health plan, or that the patients' records be sent to the health plan for internal review. The local opioid review committee would consist of a medical director, pharmacist, behavioral health specialist, or other specialists. Because the PCP knows these committee members, that PCP would be more likely to trust the recommendations than if the decision were to come from the health plan.

Challenges

Participants discussed the challenges of these approaches: Providers can resent health plan interference, and prescriber lock-in programs can be logistically difficult to implement when a practice has many covering providers. In addition, health plan conversations with PCPs can be time-consuming and difficult to scale, so the population of focus must be chosen carefully.

Training Programs and Resources

With a severe shortage of pain medicine specialists available to Medi-Cal patients, the responsibility for managing the majority of patients with chronic pain remains with primary care. Convening participants discussed the many initiatives that have been developed to help PCPs expand their capacity and comfort with managing patients with chronic pain, and reduce the need for specialist assistance.

Providing support and training via videoconferencing has proven to be one successful approach to expanding the capacity of providers with little access to pain or addiction specialists. **Project ECHO** is a highly regarded program that originated in New Mexico and now operates in California out of the University of California, Davis. The program allows PCPs to better manage complex patients through weekly video learning and case review with specialists. Originally focused on treatment of hepatitis C, Project ECHO is now used for multiple specialties, including pain management and addiction treatment. Project ECHO for pain management is supported through a CHCF-funded initiative in partnership with the Central California Alliance for Health, Partnership HealthPlan, Health Plan of San Joaquin, and the California Department of Corrections and Rehabilitation. **Open Door Community Health Centers**, a rural clinic system in the northernmost region of California, was an early adopter of Project ECHO and credits this program with improved management of chronic pain patients and the success of implementing systemwide protocols.

The San Francisco Health Plan (SFHP) sponsors free annual pain management and opioid educational events for safety-net providers to promote best practices for prescribing throughout the county. In 2014, over 100 safety-net providers and staff attended an event called Safe and Competent Opioid Prescribing Education (SCOPE) of Pain, a medical education program developed by the Boston University School of Medicine in

collaboration with the Council of Medical Specialty Societies (CMSS) and the Federation of State Medical Boards (FSMB). In addition to SCOPE, SFHP sponsored trainings on risk and evaluation, safety and efficacy, and tapering trainings, and promoted buprenorphine trainings sponsored by the San Francisco Department of Public Health.

Convening participants also expressed the need for clinicians to have easy access to standardized tools, such as opioid conversion calculators like the free smartphone app created by New York City,³² tapering calculators, assessment tools, and risk scoring tools. (See Appendix C for examples of these tools.)

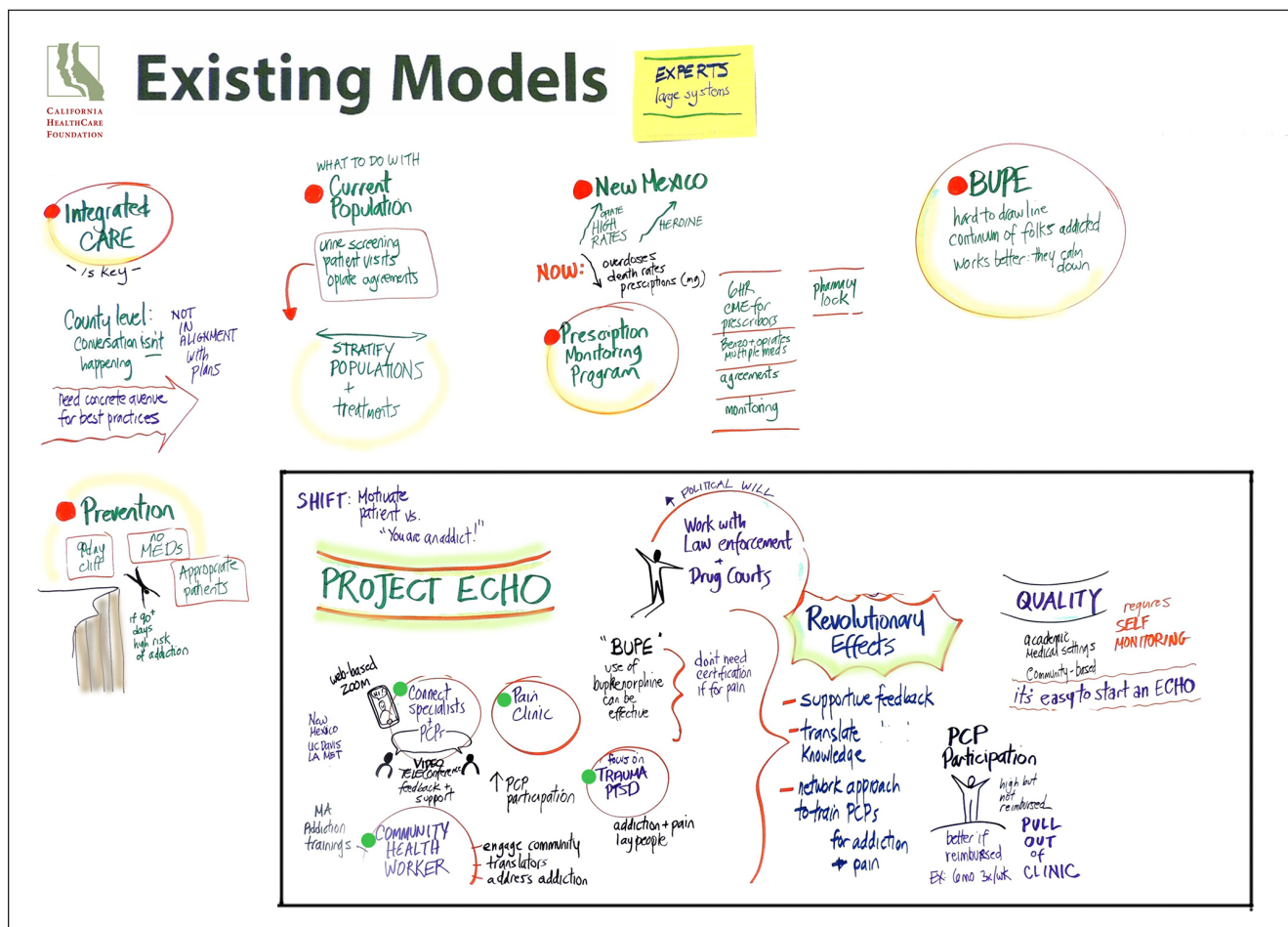
Challenges

Although all convening participants expressed the need for more provider and staff training, they acknowledge that training alone does not change behavior. Training can inform individuals, but systems within organizations need to reinforce behavior change.

Medication-Assisted Addiction Treatment and Overdose Prevention

Growing evidence supports the use of medications to improve outcomes for addiction treatment.³³ Convening participants discussed the importance of two medication options that can help decrease opioid-related deaths: buprenorphine and naloxone. Desperate patients can turn to heroin when there are no other options, and death rates can skyrocket when there is limited access to medication-assisted treatment.³⁴

Buprenorphine treatment has been proven to decrease overdose deaths for patients with opioid addiction, yet it is not available in many California regions with the highest overdose rates. To address this gap, **Partnership HealthPlan** developed a one-time financial bonus to any physician who obtains a license to prescribe buprenorphine and who accepts outside referrals for treatment. **Open Door Health Centers** has a robust addiction



Provided by Kayla Kirsh, Leapfrog Consulting

program, and encourages its providers to get buprenorphine licenses and treat patients. However, due to a regulatory limit on the number of patients each doctor can treat, Open Door has a long wait list for treatment and cannot currently meet this demand for its services.

Although obtaining a buprenorphine license requires only eight hours of training, and is easily accessible with online options, many doctors do not take the training, and many who get licensed do not accept new patients or never prescribe the drug. One reason for this resistance is the challenge of starting buprenorphine with opioid-dependent patients — an induction process is required, which can be time-consuming and difficult. Also, PCPs may lack the resources to provide substance use counseling and may be concerned about prescribing medications for patients with difficulty accessing counseling and group support. In response to these concerns, the **San Francisco Department of Public Health** developed a buprenorphine induction clinic so patients can get a full assessment, treatment plan, and buprenorphine induction, and then can be referred back to their PCP when they are stable on the medication. Several participants were interested in this model but were not sure how to implement it within their setting.

On the other hand, it is recommended that the medication naloxone be prescribed to all opioid users, not just for those diagnosed with addiction. In July 2013, **California Department of Health Care Services** added naloxone as a benefit in the Medi-Cal program, and recommended routine prescriptions for all patients who are chronic opioid users. Naloxone is used to reverse an accidental overdose and can be used by an untrained layperson, similar to how a layperson can use the auto-injector EpiPen to administer epinephrine to a person with bee or peanut allergies in an emergency. Naloxone is given by injection or nasal spray to someone experiencing an accidental or deliberate overdose, and has been proven to decrease overdose deaths for both prescription drug users and heroin users.³⁵ The act of prescribing naloxone has been shown to decrease overdose deaths even if it is never used: Researchers speculate that when patients receive naloxone and learn about the risks of opioids, they change their behavior. As part of a CHCF-sponsored grant, the San Francisco Department of Public Health developed patient and provider educational materials and is testing the impact of intensive in-person provider education on the rate of naloxone prescribing.³⁶

Challenges

Participants discussed two main challenges with increasing the availability of buprenorphine: barriers to induction (PCP reluctance or lack of an induction clinic) and concern about overuse. Because buprenorphine has been so successful in treating opioid addiction, it has been increasingly used for patients with chronic pain, without a diagnosis of addiction. Although many participants advocated buprenorphine as a much safer solution for patients tolerant to high-dose narcotics, others were very concerned about liberal prescribing — that buprenorphine would be misrepresented as a miracle drug, be overused, and then would become the drug of choice on the street.

All participants supported the spread of naloxone, but talked about the challenges of its use in the current delivery system. For example, not all pharmacies carry the atomizer that allows intranasal use. This issue will be resolved when an affordable delivery device is released, which is anticipated in 2015 or 2016.

Innovative Payment Models

The current Medi-Cal payment structure limits a clinic's ability to provide mental health, addiction treatment, complementary medicine, and primary care in an integrated approach. Certain treatments that could help patients cope with symptoms while tapering off medications, such as chiropractic care, acupuncture, or other complementary therapies, are not covered by Medi-Cal. Federally qualified health centers cannot bill a counseling and a medical visit on the same day, and certain provider types cannot bill at all, such as marriage and family therapists, nurses, and nutritionists. In addition, the services of mental health treatment, substance use treatment, and medical care can each have separate payers. Therefore, integrated care models, with multidisciplinary teams providing multiple services on one day, are difficult to launch and financially sustain in the safety net.

Commercial medical groups, on the other hand, do not have these limitations. **Synovation Medical Group**, a private, multisite, comprehensive pain clinic in Southern California, supports an integrated, multidisciplinary model. In line with the national movement toward value-based payment, the group set up an innovative payment structure where at least one-third of the payment is dependent on improvement of the patient's functional status, such as getting patients back to work, improving

self-assessment scores, and tapering patients off of opioid medications.

San Francisco Health Plan, Partnership HealthPlan, and Central California Alliance for Health have each developed incentives within their overall performance improvement, or pay-for-performance, programs to support safe prescribing. For example, starting in 2013, SFHP expanded its existing provider incentive program to include incentives to clinics for institutionalizing interdisciplinary opioid review committees. By the end of December 2014, 46% of SFHP's clinics had established these committees.

Challenges

Medi-Cal regulations make it difficult to pay for care provided in an integrated way. Health plans may create bonuses and incentives for clinics to encourage best practices, but the development of a multidisciplinary team approach integrating behavioral and physical health would require a substantially different payment model.

Models with Promise for the Safety Net: Where Can We Go from Here?

Low-income populations face higher risks of opioid-related death,³⁷ yet clinics and health plans serving this community don't have the resources necessary to ensure their patients receive the care and services they need. Convening participants reviewed examples from the varied organizations represented in the room, and then discussed what would need to happen to support better care in low-resource settings, focused both on management of high-dose opioids and prevention of opioid overuse. Eight approaches were identified by the group for implementation in California's safety net:

1. Create broad community coalitions.

Participants discussed the benefits of broad, community-wide strategies to curb opioid overuse and decrease overdose rates. This approach would require communication and collaboration between all sectors impacted by opioid overuse: payers, primary

care, specialty care, emergency departments, dentists, pharmacies, law enforcement, mental health providers, substance use treatment, jail health care, and public schools. Participants discussed the progress made by community collaborations such as the Prescribe Safe initiative in Santa Cruz, and the need to spread this model.

2. Ensure consistent clinical and operational practices.

Primary care providers are the main source of pain management treatment in the safety net. Yet there is tremendous variation in care quality and prescribing practices across primary care systems and within clinics. Participants discussed examples of clinics that were able to create cultures of patient-centered care and prescribing safety, and highlighted the following critical elements:

► Adherence to evidence-based clinic practices:

- Ensuring *standards of care are followed for all patients*, including goal setting and progress review, treatment plans, annual informed consent/treatment agreements, random urine drug screens, and CURES report review
 - Identifying dose ceilings for opioids, and setting up structures to support PCPs in *tapering patients down* to a safer opioid dose
 - Identifying and acting on signs of *opioid misuse and substance use*, such as abnormal urine drug screens, early refill requests, multiple prescribers, refusal of pill counts, and other concerning behaviors
 - Developing *common provider agreements about when to taper or discontinue opioids* — for example, due to lack of progress against goals, worsening function, or severe side effects, such as sleep apnea
 - Preventing prescriptions of *high-risk drugs*, such as methadone in doses over 30 mg, or the combination of benzodiazepines and opioids
 - Avoiding creation of new populations of *opioid-dependent patients* by setting dose limits or other limitations, such as avoiding prescribing over 90 days for new injuries
 - Creating *opioid review committees* to provide second opinions and oversight for when policy exceptions are appropriate
- **Standardized roles and responsibilities for team members**, to ensure that consistent best practices are followed.

- ▶ **Institutionalizing training for staff** on compassionate approaches for patients with pain, substance use disorders, or both. Training topics should include motivational interviewing and trauma-informed care, approaches that help staff build trust with patients and prevent escalations.
- ▶ Incorporation of **standardized assessment tools** into workflows and electronic health records. Examples include SBIRT (alcohol and substance use screen), PHQ-2 (depression screen), ORT (Opioid Risk Tool), DIRE (Diagnosis, Intractability, Risk, Efficacy) tool, PEG questionnaire (pain level, enjoyment, general function). (See Appendix C for details.)
- ▶ **Integration of behavioral health services** into primary care, including mental health and substance use services.
- ▶ **Expanded resources for patients**, including group visits and education sessions, and complementary and alternative medicine options.

3. Offer training programs and resources.

Participants talked about the need to institutionalize educational tools to expand the ability of PCPs and staff to compassionately and safely manage patients who have chronic pain, use opioids, or suffer from addiction. Convening participants discussed hosting a SCOPE of Pain conference (faculty are available for free; online options are available) and offering trainings in trauma-informed care and motivational interviewing to all providers and staff.

4. Create multidisciplinary teams.

Convening participants agreed on the merits of using a multidisciplinary, coordinated approach to managing patients with pain and other complex conditions and those on high-dose opioids. Convening participants discussed the benefits of incorporating new, integrated team roles:

- ▶ Pharmacists to provide medication therapy management, with a focus on opioid safety and naloxone use. Pharmacists could play a key role in helping patients taper to safer doses.
- ▶ Primary care providers trained to provide specialized pain medicine and addiction treatment.
- ▶ Physical and occupational therapists and personal trainers to help patients increase their activity levels.
- ▶ Behavioral health providers and behavioral assistants with basic training in pain management to help patients set health goals.
- ▶ Substance use counselors or peer coaches, to help patients cope with the stresses and challenges of the early stages of recovery.
- ▶ Complementary and alternative medicine providers, to provide alternatives to pills for pain flares.
- ▶ Care coordinators and case managers, to help patients access food, housing, and other needed community resources.
- ▶ Health educators, to lead classes in back pain management strategies, coping mechanisms, and mindfulness.

5. Spread medication-assisted addiction treatment options.

The participants discussed medications that have been shown to effectively decrease overdose deaths but that are underused. Potential strategies to increase the use of these medications include:

- ▶ Provider education on the use of naloxone to treat overdoses for all patients who are chronic opioid users, and patient education about the risk of accidental death with chronic use of high-dose opioids.
- ▶ Incentives for prescribers to obtain a buprenorphine license and accept new referrals.
- ▶ Establishment of buprenorphine induction clinics to allow providers with new buprenorphine licenses to maintain patients on the drug without having to manage the challenges of starting patients on the drug, which can be time-consuming.

6. Use health plan tools to support safer prescribing.

Participants discussed the need for plans to work closely with provider stakeholders to develop helpful and fair opioid use policies, and to be thoughtful when developing provider-level reporting and communications to ensure relevant and actionable information for the PCP.

7. Explore payment reform.

Participants discussed the challenges of working in systems where reimbursement mechanisms create barriers to accessing integrated care. Medical care, mental health care, and substance use treatment have different funding streams and are often provided by organizations working in isolation, making it difficult to share information and data. Ideally, payment for care would be partially or fully integrated, and include payment for outcomes and not just for services. Convening participants were interested in the payment model used by Synovation Medical Group,

where significant payment incentives are given when patients reach certain positive outcomes: returning to work, improving functional status, improving quality of life, and tapering off of opioids.

Participants discussed options that would be feasible in the safety net:

- ▶ **Benefit expansion**, which would require defining subpopulations of high-risk or high-cost patients eligible for additional benefits, such as intensive physical therapy, occupational therapy, or complementary care services, such as chiropractic care, acupuncture, or other alternative medicine options.
- ▶ **Bundled payment**, such as increased capitation rates or lump payments for clinics designed to evaluate and manage complex patients, including those with high ED use, high-dose opioid use, or opioid use disorder. Integrated teams would support tapers and buprenorphine induction, and provide complex care management services.
- ▶ **Integrated payment or a global budget**, to allow the cost of mental health and substance use services to be covered by cost savings from decreased pharmacy, emergency department, or hospital costs.

8. Develop and report outcome measures.

Participants discussed the need to develop public health and clinical measures to identify regions of the state that are the most impacted by use of high-dose opioids and to track the success of interventions over time. Examples of these measures include opioid overdose rate, opioid-related emergency department or hospital use, number of opioid prescriptions per capita, and the multiple-prescriber rate — the percentage of patients receiving medications from four or more providers. These efforts require streamlined and reliable data collection across providers and payers, and financial or policy incentives to ensure that measures are tracked.

Conclusion

Most patients on high-dose prescribed opioids did not get there on their own; they took medications in good faith, prescribed by well-meaning providers. The group of experts over the course of the day reviewed the complex circumstances that created the problem, and the many approaches it will take to solve it. They committed to immediate actions in their organizations (see Appendix E).

The truism “the future is already here — it’s just not evenly distributed”³⁸ is apparent in this field; this paper lists various models being piloted or spread in communities across California (see Appendix B for a list of resources). There is much work to do to make sure these best practices reach those who need them the most.

Appendix A. Participating Organizations

Health Plans

CalOptima

Leora Fogel, PharmD, clinical pharmacist, Pharmacy Management

CalOptima is a county-organized health system that administers health insurance programs for low-income families, children, seniors, and persons with disabilities in Orange County. The second-largest health insurer in the county, CalOptima serves more than 600,000 members.

CareOregon

Amit Shah, MD, medical director, Informatics

The nonprofit health plan CareOregon serves 250,000 patients throughout the state. The organization provides health plan services to four coordinated care organizations, and serves Medicaid and Medicare members.

Central California Alliance for Health

Dale Bishop, MD, chief medical officer

The Central California Alliance for Health is a regional nonprofit health plan that serves over 236,000 members in Merced, Monterey, and Santa Cruz Counties.

Inland Empire Health Plan

William Henning, DO, chief medical officer

Peter Currie, PhD, director, Behavioral Health

Inland Empire Health Plan is a nonprofit Medi-Cal and Medicare health plan with over one million members, serving Riverside and San Bernardino Counties.

LA Care Health Plan

Clayton Chau, MD, PhD, medical director, Behavioral Health

LA Care Health Plan is an independent local public agency created by the State of California to provide health coverage to low-income Los Angeles County residents. With more than 1.6 million members, LA Care is the nation's largest publicly operated health plan.

Partnership HealthPlan

Robert Moore, MD, MPH, chief medical officer

Partnership HealthPlan of California, a nonprofit community-based health care organization, contracts with the state to administer Medi-Cal benefits through local care providers. Partnership provides care to over 510,000 members in 14 Northern California counties.

San Francisco Health Plan

Elizabeth Sampsel, PharmD, director, Pharmacy Services

San Francisco Health Plan, a licensed community health plan, was created by the City and County of San Francisco to provide affordable health care coverage to over 130,000 low- and moderate-income families.

County and Community Clinic Systems

Alameda Health System

Sharone Abramowitz, MD, director, Behavioral and Addiction Medicine

Nick Nelson, MBBS, attending physician

Alameda Health System (AHS) is an integrated public health care system with over 800 beds and 1,000 physicians across nine major facilities throughout Alameda County. Highland Hospital, the AHS county hospital, has one internal and four outlying primary care clinics.

Northeast Valley Health Corporation

Reneé M. Poole, MD, MMM, FAAFP, medical director, Adult Medicine

Northeast Valley Health Corporation is a federally qualified health corporation serving the San Fernando and Santa Clarita Valleys. The organization provides comprehensive primary health care to the region's medically underserved population.

Open Door Community Health Centers

Bill Hunter, MD, medical director

Open Door Community Health Centers operates nine clinics serving the populations of Humboldt and Del Norte Counties. The clinics see 45,000 patients a year and employ over 400 members of the community.

Petaluma Health Center

Nurit Licht, MD, chief medical officer

Petaluma Health Center is a federally qualified health center that provides primary medical care and mental health services to 23,000 residents of Cotati, Penngrove, Petaluma, Rohnert Park, and the surrounding areas.

Rancho Los Amigos National Rehabilitation Center

Mindy Aisen, MD, chief medical officer

Rancho Los Amigos National Rehabilitation Center, a rehabilitation hospital in Downey, California, is licensed for 207 beds, cares for 4,000 inpatients, and conducts 78,000 outpatient visits annually.

Riverside County Regional Medical Center

Edward Bacho, MD, physician lead, Eastern Region

Riverside County Regional Medical Center serves Riverside County residents with a focus on underserved populations.

Government and Community Coalitions

California Department of Health Care Services

James J. Gasper, PharmD, psychiatric and substance use disorder pharmacist, Pharmacy Benefits Division

The California Department of Health Care Services (DHCS) manages 10 million patients a year. Its mission is to provide Californians with access to affordable, high-quality health care, including medical, dental, mental health, substance use disorder services, and long-term services and supports. The DHCS Pharmacy Benefits Division is responsible for the department's Medi-Cal fee-for-service drug program and for the management of the Medi-Cal managed care pharmacy program.

Health Improvement Partnership of Santa Cruz County

Jennifer Hastings, MD, consultant, Health Improvement Partnership of Santa Cruz County, and assistant clinical professor, UCSF Department of Family and Community Medicine

The Health Improvement Partnership (HIP) is a nonprofit coalition of public and private health care leaders dedicated to increasing access to health care and building stronger local health care systems in Santa Cruz County, with a focus on the safety net. Launched in 2004, HIP's member organizations represent Santa Cruz County's major health care providers and other key community stakeholders.

Other Experts

California Mental Health Services Act (CalMHSA) Integrated Behavioral Health Project (IBHP)

Karen Linkins, PhD, director

As part of its statewide Stigma and Discrimination Reduction Initiative, the California Mental Health Services Authority funds IBHP to advance and spread integrated health systems and care by providing training and technical assistance at the state, regional, and county levels. CalMHSA is an organization of county governments working to improve health outcomes for

individuals, families, and communities, and administers programs funded by the Mental Health Services Act (Prop 63 — the “millionaires tax”).

Kaiser Permanente Santa Rosa

Andrea Rubinstein, MD, chief, Department of Chronic Pain

Kaiser Permanente Santa Rosa manages 300,500 patients a year and is part of the larger Northern California system of The Permanente Medical Group.

Kaiser Permanente — Southern California Permanente Medical Group

Steven Steinberg, MD, regional chief, Family Medicine

Kaiser Permanente — Southern California serves Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Ventura Counties.

Project ECHO

Miriam Komaromy, MD, FACP, associate director, Project ECHO, and associate professor of medicine, University of New Mexico Health Sciences Center

Originating in New Mexico, Project ECHO provides training for PCPs to help them provide care for common complex diseases that are typically handled by specialists. California Project ECHO is run through the University of California at Davis (representatives were unable to attend this convening). ECHO connects specialists with PCPs all over the state via simultaneous multipoint video conferencing. The PCPs present actual (de-identified) cases and receive input from specialists. Project ECHO covers many specialties, including chronic pain and addiction treatment.

Synovation Medical Group

Clayton Varga, MD, CEO

Synovation Medical Group, located in Southern California, provides innovative care in pain management and physical medicine within an interdisciplinary rehabilitation model.

Independent Consultant

Anthony Mariano, PhD, clinical psychologist, pain medicine

Appendix B. Resources

Educational Resources

California Prescription Drug Monitoring Program, CURES registration, https://pmp.doj.ca.gov/pmpreg/RegistrationType_input.action

Medical Board of California, 2014 Guidelines for Prescribing Controlled Substances for Pain, www.mbc.ca.gov/licensees/prescribing/pain_guidelines.pdf

Naloxone patient pamphlet, “Understanding Naloxone and How to Use It” and provider pamphlet, “The Case for Prescribing Naloxone and How to Prescribe It,” www.chcf.org/naloxonesafety

New York City Department of Health and Mental Hygiene, Morphine milligram equivalent (MME) calculator, available as free app, www.nyc.gov/html/doh/html/mental/MME.html

Oregon Pain Guidance group prescribing guidelines, including a toolkit, templates, and reference list, www.southernoregonopioidmanagement.org/opioid-prescribing-guidelines

Safe and Competent Opioid Prescribing Education (SCOPE) of Pain, www.scopeofpain.com

Tapering calculator, embedded in Andrea Rubinstein, MD, Departments of Anesthesiology and Chronic Pain, Kaiser Permanente Santa Rosa presentation: “Art and (Very Little) Science of Tapering Opioid Medications,” www.sfhp.org/files/providers/Best_Practices/AR_SF_Partnership_tapering_June.pptx (PowerPoint document)

Washington State Department of Social and Health Services, Health and Recovery Services Administration, Tapering Plan for Client with Chronic, Non-Cancer Pain (tapering calculator), www.hca.wa.gov/medicaid/pharmacy/Documents/taperschedule.xls (Excel document)

Regional Collaboratives

Resources and guidelines for launching community coalitions.

Marin County: Safe Pain Medicine Prescribing in Emergency Departments, www.marinhhs.org/sites/default/files/files/public-health-updates/phadvisorydrugoverdoses_10jul14_0_combined.pdf

Monterey County: Prescribe Safe initiative, www.chomp.org/for-healthcare-professionals/prescribe-safe/#.VNg6BfnF_k0

New York City: RX Stat Technical Assistance Manual, www.pdmpassist.org/pdf/RxStat.pdf

Partnership HealthPlan: Managing Pain Safely website, including clinical guidelines for primary care, emergency departments, and pharmacy, www.partnershiphp.org/Providers/HealthServices/Pages/Managing-Pain-Safely.aspx

San Diego: Safe Prescribing, www.sandiegosafe-prescribing.org

Appendix C. Screening and Assessment Tools

PEG Tool (Pain/Enjoyment/General Activity)

1. What number best describes your pain on average in the past week:											
0	1	2	3	4	5	6	7	8	9	10	
No pain										Pain as bad as you can imagine	
2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?											
0	1	2	3	4	5	6	7	8	9	10	
Does not interfere										Completely interferes	
3. What number best describes how, during the past week, pain has interfered with your general activity?											
0	1	2	3	4	5	6	7	8	9	10	
Does not interfere										Completely interferes	

Source: Erin E. Krebs et al., "Development and Initial Validation of the PEG, a Three-Item Scale Assessing Pain Intensity and Interference," *Journal of General Internal Medicine* 24, no. 6 (June 2009): 733–38, www.ncbi.nlm.nih.gov/pmc/articles/PMC2686775/.

Opioid Risk Tool (ORT)

Questionnaire developed by Lynn R. Webster, MD, to assess risk of opioid addiction.

Mark Each Box That Applies	Female	Male
Family History of Substance Abuse		
Alcohol	<input type="checkbox"/> 1	<input type="checkbox"/> 3
Illegal Drugs	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Rx Drugs	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Personal History of Substance Abuse		
Alcohol	<input type="checkbox"/> 3	<input type="checkbox"/> 3
Illegal Drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
Rx Drugs	<input type="checkbox"/> 5	<input type="checkbox"/> 5
Age Between 16 – 45 Years	<input type="checkbox"/> 1	<input type="checkbox"/> 1
History of Preadolescent Sexual Abuse	<input type="checkbox"/> 3	<input type="checkbox"/> 0
Psychologic Disease		
ADD, OCD, Bipolar, Schizophrenia	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Depression	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Scoring Totals		

ADMINISTRATION

- On Initial Visit
- Prior to Opioid Therapy

SCORING/RISK

0-3: Low
4-7: Moderate
≥8: High

Source: Lynn Webster, "Predicting Aberrant Behaviors in Opioid-Treated Patients: Preliminary Validation of the Opioid Risk Tool," *Pain Medicine* 6, no. 6 (2005): 432, www.lynnwebstermd.com/opioid-risk-tool/.

D.I.R.E. Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1 to 3 based on the explanations in the right-hand column.

Score Factor Explanation

Diagnosis	<p>1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, nonspecific back pain.</p> <p>2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain.</p> <p>3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.</p>
Intractability	<p>1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process.</p> <p>2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness).</p> <p>3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.</p>
Risk	(R = Total of P + C + R + S below)
Psychological	<p>1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues.</p> <p>2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder.</p> <p>3 = Good communication with clinic. No significant personality dysfunction or mental illness.</p>
Chemical Health	<p>1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse.</p> <p>2 = Chemical coper (uses medications to cope with stress) or history of CD in remission.</p> <p>3 = No CD history. Not drug-focused or chemically reliant.</p>
Reliability	<p>1 = History of numerous problems: medication misuse, missed appointments, rarely follows through.</p> <p>2 = Occasional difficulties with compliance, but generally reliable.</p> <p>3 = Highly reliable patient with meds, appointments & treatment.</p>
Social Support	<p>1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles.</p> <p>2 = Reduction in some relationships and life roles.</p> <p>3 = Supportive family/close relationships. Involved in work or school and no social isolation.</p>
Efficacy Score	<p>1 = Poor function or minimal pain relief despite moderate to high doses.</p> <p>2 = Moderate benefit with function improved in a number of ways (or insufficient info — hasn't tried opioid yet or very low doses or too short of a trial).</p> <p>3 = Good improvement in pain and function and quality of life with stable doses over time.</p>

_____ **Total score = D + I + R + E**

Score 7-13: Not a suitable candidate for long-term opioid analgesia

Score 14-21: May be a candidate for long-term opioid analgesia

Source: Miles Belgrade, Fairview Pain & Palliative Care Center, www.opioidrisk.com/node/1202.

Appendix D. Contraindications for Opioid Use

Summary of Portland Public Health Guidelines: Contraindications to prescribing opioids

Category	Evidence and Rationale	Approach
INCREASED RISK OF OVERDOSE AND DEATH		
Active substance use: any illicit or nonprescribed medication use in the past 12 months (including THC) Any history of diversion In methadone treatment Co-occurring benzodiazepine use	<p>Thirty percent of chronic pain patients meet criteria for substance use disorder.³⁹</p> <p>Patients with active substance use disorder or alcohol abuse are at increased risk of death.⁴⁰</p> <p>Over 75% of overdoses were in people with a history of substance abuse.⁴¹</p> <p>Combined benzodiazepines and opioids greatly increases overdose risk.^{42,43,44}</p> <p>California Medical Board guidelines⁴⁵ do not support prescribing opioids in the face of active substance use.</p>	<p><i>First episode</i> initiates a compassionate and firm conversation, review of treatment agreement and clinic guidelines.</p> <p><i>Recurrent use</i> indicates a pattern and loss of control.</p> <p><i>Options</i> include immediate buprenorphine induction, slow taper, or rapid taper based on circumstances.</p>
Morphine equivalent greater than 120 mg	Risk of accidental overdose increases incrementally with increasing dose. ⁴⁶	Supported, structured dose tapers over several months, better results with high-touch approach.
High risk score on validated assessment tool	Four or more aberrant behaviors are a strong predictor of substance use disorder. ⁴⁷	<p>Use validated assessment tools: Opioid Risk Tool⁴⁸</p> <p>Screeners and Opioid Assessment for Patients with Pain (SOAPP-R)⁴⁹</p> <p>Diagnosis, Intractability, Risk, Efficacy (DIRE) tool⁵⁰</p>
UNTREATED BEHAVIORAL HEALTH CONDITION		
No behavioral health screening, or lack of engagement in treatment History of suicide attempt in past two years, or history of suicide attempt with pills	<p>Forty percent of overdoses were in people with mental illness.⁵¹</p> <p>Cognitive behavioral therapy can improve function and decrease suffering in chronic pain.^{52,53}</p>	<p>Screen all patients for depression and anxiety; consider routine behavioral health assessment.</p> <p>Taper opioids if no follow-through on indicated referrals.</p>
LACK OF BENEFIT		
No functional improvement on opioids	<p>Medical Board guidelines require treatment plan and documentation of goals and functional status.⁵⁴</p> <p>No evidence that chronic opioid use increases function and controls pain but abundant evidence of harm.^{55,56}</p>	<p>All patients receive thorough assessment for pain diagnosis, functional status.</p> <p>Ongoing opioid therapy is tied to progress toward specific goals and follow-through with treatment.</p>

Source: Amit Shah, MD, medical director, CareOregon.

Appendix E. Areas of Potential Action

Summary of participants' next actions — ideas to implement in their home organizations

Payers/Plans

Behavioral/physical health integration

- Create a behavioral health integration guide/toolkit for public Medi-Cal health plans (instead of contracting all services out to a vendor)
- Integrate behavioral health / medical services within the health plan
- Create integrated team model for this population, and reassign high-risk/high-dose members

Develop PCP education programs and resources

- Host SCOPE of Pain training
- Replicate Kaiser model (multidisciplinary tapering clinic)
- Add pain management option to behavioral health referrals
- Create incentives for and spread buprenorphine certification and use (including buprenorphine induction clinics)
- Implement comprehensive provider educational program
- Spread Project ECHO for chronic pain and buprenorphine support; incorporate in new waiver planning
- Ensure all PCPs and other prescribers access to CURES database before prescribing opioids and benzodiazepines

Payment reform

- Evaluate options for outcome-based payment and case rates for multidisciplinary pain clinics
- Bundle payment for this population based on outcomes, using measures such as quality of life, service utilization, etc.

Stratification

- Run algorithm to segregate subpopulations of opioid misuse
- Evaluate subpopulations and develop targeted interventions

Outcomes

- Help define statewide outcomes of success and measurement strategies for chronic pain patients

Center of excellence

- Apply population health care principals to target narcotic misuse subpopulations (complex pain, addicted, drug seeking, etc.) in new pilot center of excellence
- Set up learning collaborative for small group of health plans, to share best practices during pilot of center of excellence (training costs, blended funding model)

Case management

- Increase direct case management for high-dose patients
- Leverage the health plan care team to coordinate care

Clinics

Clinical pathways and standard protocols

- Develop systemwide consensus on best-practice prescribing policies, addressing common problems (new starts, 90-day threshold, dose ceilings, management of aberrant behaviors and abnormal urine drug screens, opioid contraindications, tapering guidelines)
- Implement model for pain management office visits, including identified roles for nurses, medical assistants, behavioral providers
- Implement universal, mandatory use of:
 - Pain management templates and tools
 - Standardized risk assessments
 - Controlled medication use agreements for all patients on chronic opioid therapy
 - Standardized documentation of initiation and maintenance
 - Goal setting (and following progress on goals and functional status, discontinuing opioids if no progress)
 - Standardized monitoring by CURES report and drug screens

Education and training

- Develop provider education, and offer tools for dealing with high-dose opioids, supporting both safe prescribing and empathy
- Cross-train all staff members for integrative team approach
- Expand resident chronic pain training

Naloxone distribution

- Promote naloxone, and distribute to appropriate patients

Population management

- Identify measurable outcomes, utilization, high-risk utilizers
- Work with electronic health records and registries to extract data and provider-level reports
- Define patient populations, segmentation (high-dose prescriptions, opioid-related ED visits), outcomes, and action plan for target populations

Team model for consultation or care

- Case-based collaborative consult model (like Project ECHO), but on-site, with interdisciplinary team looking at:
 - Opioid management approaches
 - Counseling approaches
 - Complementary and alternative medicine approaches
 - Offering plan to PCPs

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