Marshall Kubota, MD, Regional Medical Director, Partnership HealthPlan

Community Prescribing Guidelines

Dr. Marshall Kubota, a regional medical director for Partnership HealthPlan of California, joined us for an hour discussion about how Partnership developed prescribing guidelines and what advice their experience provides to others.

Dr. Kubota started with a discussion about primary care, but emphasized that the process and learnings from implementation in primary care are applicable to other specialties and settings. A key theme: it is vital to involve the entire community to make sure that you are sending a consistent message to patients and reducing opportunities for "leakage" (clamping down in one sector, and then having patients receive excess opioids in urgent care, emergency departments, specialists, dental, pharmacies, and Illicit sources.)

We are familiar with the cycle: treatment of pain began with cancer treatment and then expanded to broad use for minor conditions with the advent of synthetic opioids. With widespread opioid use, patients are broadly impacted: decreased function, addiction, ineffective treatments, and overdose deaths. For clinicians, this has created conflicting feelings of dissatisfaction, guilt and fear, feelings of ineffectiveness, and patient relationships devolving into suspicion instead of trust. For health care systems, this has driven up costs, resulted in displacement of care, and necessitated partnerships with law enforcement and others to protect the public safety.

It's important to recognize the difficulty in behavior change for clinicians. Foundational knowledge about volume vs. quality is important, to dispel misconceptions about the effectiveness of long-term opioid treatment, and become familiar with alternative modalities for the treatment of pain. We need to equip clinicians with ways to talk to patients. One place to start is by developing guidelines and policies.

- ***Guidelines*** will be widely applicable across entities, allow for some interpretation, depending on the nature of situation. They may or may not result in desired degree of change.
- ***Policies*** go a step further by reducing or removing choices, especially where those choices do not add value or would not follow evidence. Policies can be enforced at the health plan, medical system or clinic/practice level. A good thing about policies is that they remove or relieve the responsibility from the clinician – and allow the clinicians to "pass the blame" and explain to patients that the clinic or health plan policy requires us to go in this direction, AND that, as a doctor, I agree with this choice. Policies can reduce variation between entities (e.g., counties, practices, prescribers) if uniformly developed and applied.

Two physicians participating on this call gave examples of their success in using guidelines in Emergency Departments. For example, in one community, there is a policy that the ED no longer refills lost opioid prescriptions for chronic pain, and refers patients back to their primary care provider. The adoption of this policy empowers physicians to say "no." Another ED routinely gives patients a handout about safe prescribing, developed by the California American College of Emergency Physicians, after registration and screening (if given as part of the discharge packet, it avoids EMTALA concerns). The pamphlet covers the ED pain policies includes local treatment phone numbers.
http://californiaacep.org/improving-health/safe-prescribing/

Dr. Kubota describes the process of creating community guidelines as "successfully walking with a shallow pan of water." By creating community standards, it prevents the pan from tipping, and all the patients moving from one practice to descend upon another. Some key pieces of advice are:

- Do it as a community – involve as wide a group as possible to minimize leakage and encourage consistency. Unevenness in prescribing patterns are quickly discovered in the patient community (including Yelp recognition for easy prescribing).
- Build a sense of urgency, and use data to back up the case. There are statewide CURES data, and local data is more helpful. Engage local health plans in getting this data. Build a dashboard. Include things like:
    - User rates in county
    - Overdose and poisonings morbidity and mortality (County Health Rankings)
- Identify champions, such as Public Health Department or a health plan.
- Emphasize the benefits of working together
- Use existing guidelines and modify them to local needs – they are plentiful. Partnership developed the guidelines with clinician/prescriber input. Started with Southern Oregon guidelines, convened clinicians, and got through this in one day.
    - Partnership Health Plan shares their guidelines and toolkits at:

http://partnershiphp.org/Providers/HealthServices/Pages/Managing-Pain-Safely.aspx

- Top priorities to work on include addressing the high dose patient and setting a dose limit (whether you use CDC 90 MEDs or Oregon 120 MEDs). Look at all patients above that and work to taper those patients down; find alternative treatment modalities and involve behavioral health.
- Partnership's outcomes are very encouraging: so far they have had
    - ~50% reduction in total MEDs, # Rx, # initial Rx.
    - Results are thankful clinicians and reduced costs (both direct pharmacy costs and indirect savings, like reduced hospitalizations).
    - In addition, have been able to reallocate clinical time (mostly by decreased numbers of patients getting started on chronic medications, which means less time by clinicians managing opioid refills). They think this will ultimately be helpful in recruiting primary care physicians, who know that they won't necessarily be put in these difficult situations.
    - In the future, they plan to measure initial poisonings and overdoses. Want to treat suffering, not just pain.