Managing Pain Safely Forum

October 28, 2014

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OUR CHALLENGE

MANAGING PAIN SAFELY FORUM
ROBERT MOORE, MD, MPH
OCTOBER 28, 2014

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

- **Mission:** *To help our members, and the communities we serve, be healthy*
- **County Organized Health System (Medi-Cal Managed Care)**
- **490,000 members in 14 counties**
- **Not-for-profit**

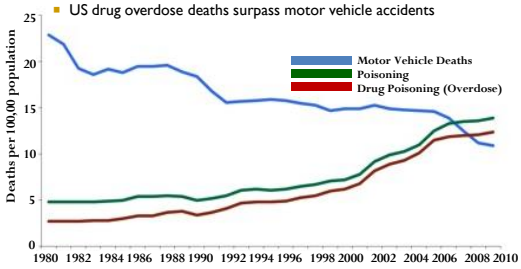
OUR CHALLENGE

- The death rate from opioid overdose has quadrupled in the US in the last decade
  - 15,000
    - Nearly 15,000 people die every year of overdoses involving prescription painkillers
  - 1 in 20
    - In 2010, 1 in 20 people in the US (age 12 or older) reported using prescription painkillers for nonmedical reasons in the past year
  - 1 Month
    - Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for one month

Chart taken from the CDC http://www.cdc.gov/vitalsigns/PainkillerOverdoses/index.html

INCREASED DEATHS DUE TO PRESCRIPTION OPIOID OVERDOSE

- US drug overdose deaths surpass motor vehicle accidents



Source: Warner et al. (2011) updated with 2009 and 2010 mortality data by Jones (2012).

BUSINESS CASE

- Almost all prescription drugs involved in overdoses originate from prescriptions
  - Roughly 20% of prescribers prescribe 80% of all prescription painkillers

CDC Website http://www.cdc.gov/homeandrecreationalsafety/rxbrief/

COMBATING THE PROBLEM

- CDC RECOMMENDATIONS
  - Prescription Drug Monitoring Program (PDMP)
    - California's Controlled Substance Utilization Review and Evaluation System (CURES)
  - Patient review and restriction programs
  - Healthcare provider accountability
  - Laws to prevent prescription drug abuse and diversion
  - Better access to substance abuse treatment

CDC Website http://www.cdc.gov/homeandrecreationalsafety/rxbrief/

PHC'S CALL TO ACTION

PARTNERSHIP HEALTHPLAN of CALIFORNIA

TACKLING THE PROBLEM

- Understanding the historical context of opioids
- Building a framework to organize the work
- Developing and executing the work plan

HISTORICAL CONTEXT

- 4000 BCE
  - First recorded images of opium poppy appeared in ancient Sumeria
- 1800s
  - Opium used for medicinal purposes for prolonged periods, leading to widening opium addiction and overdoses
- 1914
  - Harrison Narcotics Tax Act
    - Banned non-medical use of opium
    - Addiction declined
    - Reports of medical profession's undertreatment of pain increased

HISTORICAL CONTEXT (CONTINUED)

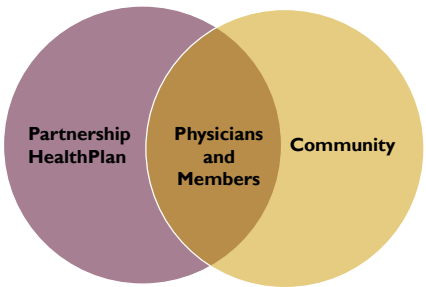
- 1970
  - Controlled Substances Control Act passed
    - Loosened restrictions of Harrison Act

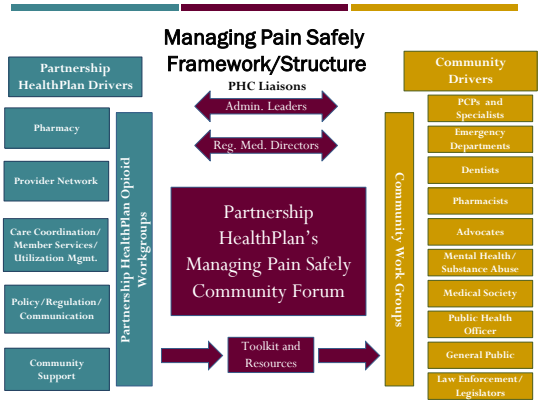
- 1970 – 1990
  - New legislation punishes healthcare professionals and institutions for under-treating pain
  - New long-acting opioids released
  - Large marketing campaign begins
    - "No upper limit"

HISTORICAL CONTEXT (CONTINUED)

- 2005 – 2010
  - Evidence accumulates regarding the dangers of prolonged opioids
    - Addiction, hyperalgesia, and decreasing function
- 2010 – 2013
  - Major national organizations release guidelines recommending limiting use of opioids in chronic, non-cancer, non-terminal pain

COORDINATING EFFORTS





PHC'S FIVE WORKGROUPS

Pharmacy	• Formulary Enhancements • TAR process to decrease inappropriate escalations • Identify medications to support tapering
Provider Network	• Survey providers to assess needs • Develop provider toolkit • Develop and offer educational opportunities
Care Coord./UM/ Memb. Svcs.	• Develop internal processes to support formulary changes • Care Coordination escalation team • Staff education (including process flow maps/scripts)
Communication Support	• Support established community initiatives • Initiate new community efforts
Community Support	• Serve as liaison to government representatives • Coordinate opportunities for information sharing and raising awareness

IDENTIFIED KEY LEVELS OF INTERVENTION

- For patients without active cancer or near the end of life:
  - Caution when starting use of chronic opioids
  - Avoid escalation of total opioid dose
    - Beyond 120 mg Morphine Equivalent Dose pre day
    - Avoid further escalation of those already on high doses
  - Improve treatment for those on already on continuing high doses
    - Refer patients with abuse
    - Taper or stop patients with diversion
    - Develop multi-disciplinary program for patients with chronic pain

MANAGING PAIN SAFELY MILESTONE #1

- Formulary Enhancement – October 1, 2014
  - **Restricted Quantity Limit (QL):** All PHC formulary opioids have an established QL for each single-dose strength, not to exceed a maximum daily dose of 120 mg. Morphine Equivalent per Day (MED)
  - **Formulary Status Change:**
    - **Morphine 100 mg and 200 mg ER tables are designated as non-formulary I lieu of a QL restriction**
    - **Methadone concentrate and Methadone 40 mg. tablets are designated as non-formulary in lieu of a QL restriction**
  - **Refill Too Soon:** A prescription for all opioids is considered to be filled "too frequently" if less than 90% of the days supply since the last fill have not elapsed.

MANAGING PAIN SAFELY MILESTONE #2

- Managing Pain Safely Forum
  - An opportunity to:
    - Learn from a diverse set of presenters on how to balance the use of opioids for healing, while avoiding harm
    - Unite providers, prescribers medical office staff, pharmacists, and community stakeholders to champion appropriate use of opioids in the communities we serve.

OBJECTIVES FOR TODAY

- To educate participants regarding the impact of opioids in our communities
- To provide practical tools for communicating with patients and family members regarding opioid use
- To raise awareness regarding safe and at-risk prescribing behaviors
- To provide a vehicle for networking with other healthcare professionals and stakeholders regarding community efforts

LET'S GET STARTED

ENJOY THE DAY!

CALIFORNIA HEALTHC

CHECK BACK SOON:
Dr. Kelly Pfeifer's presentation slides on "The Physician's Role" are pending updates.

Kelly Pfeifer, MD,
Director, Better Chronic Disease Care
October 28, 2014

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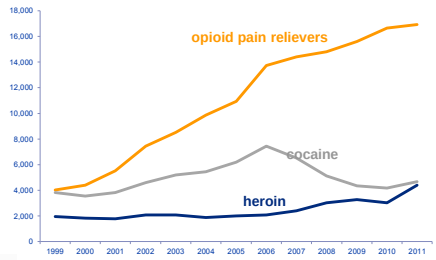
Opioid Use and Deaths: Epidemiology and Policy

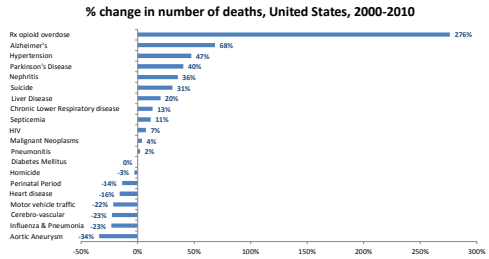
Ronald W. Chapman, MD, MPH
State Health Officer and Director
California Department of Public Health

Dramatic increase in U.S. overdose deaths related to opioid pain relievers since 1999



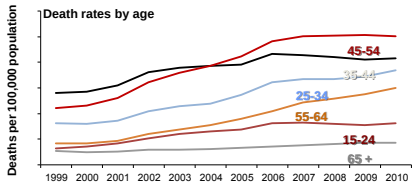
Source: National Center for Health Statistics, National Vital Statistics System

Opioid pain reliever-related overdose deaths increasing at a faster rate than deaths from any major cause

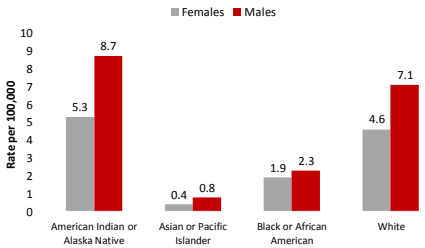


WISQARS, 2000 and 2010; CDC/NCHS, National Vital Statistics System

Middle-aged adults are at greatest risk for drug overdose in the United States



Males, American Indians/Alaska Natives, and Whites at highest risk for opioid overdose deaths

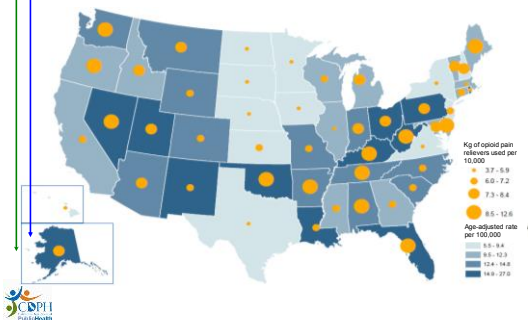


National Vital Statistics System; crude rates, 2009

Opioid pain reliever prescribing rates vary by state

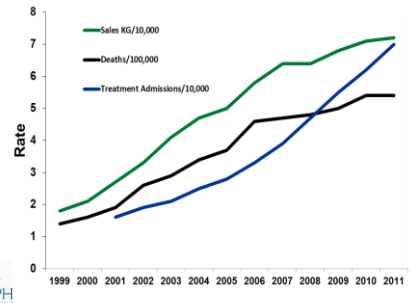
CDC Vital Signs, July 2014. Rates per 100 people in 2012

Opioid prescribing rates correlate with drug overdose death rates



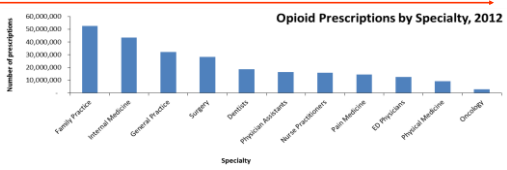
Death rate, 2008, National Vital Statistics System. Opioid pain reliever sales rate, 2010, DEA's Automation of Reports and Consolidated Orders System

Opioid-related overdose death rates and treatment admissions increased over time along with opioid sales

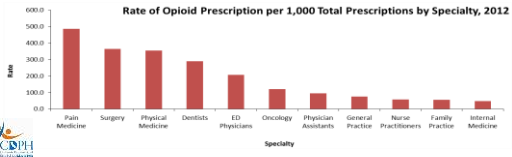


United States, 1999-2011. National Vital Statistics System, DEA's Automation of Reports and Consolidated Orders System, SAMHSA's TEDS. Treatment admission rates are per 10,000 people ages 12+.

Primary care providers prescribe the most opioids

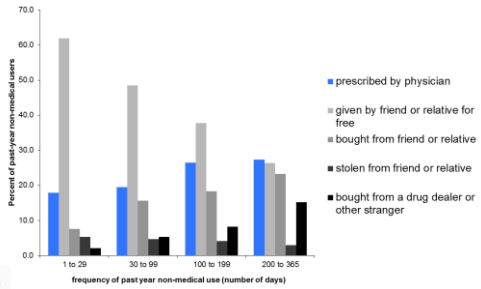


Pain specialists prescribe opioids most frequently

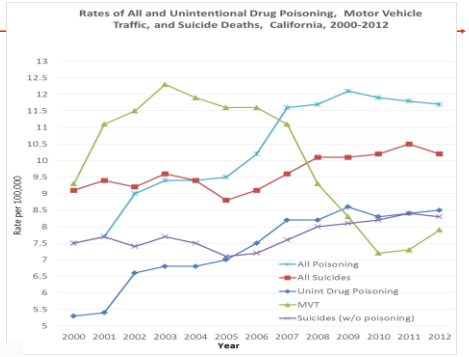


IMS Health, National Prescription Audit, United States, 2012

Doctors most common source of opioids for most frequent nonmedical users



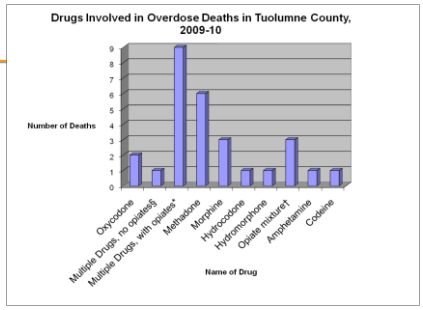
Jones CM, Paulozzi LJ, Mack KA. Sources of prescription opioid pain relievers by frequency of past-year nonmedical use: United States, 2008-2011. JAMA Internal Medicine. 2014



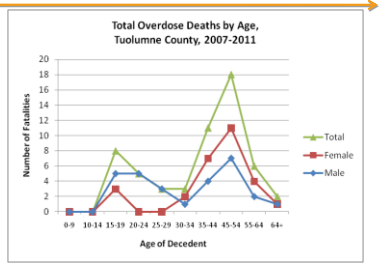
Prepared by Safe and Active Communities Branch, California Department of Public Health (CDPH)
Report generated from http://epicenter.cdph.ca.gov on March 20, 2014
Data Sources: CDPH Vital Statistics Death Statistical Master Files

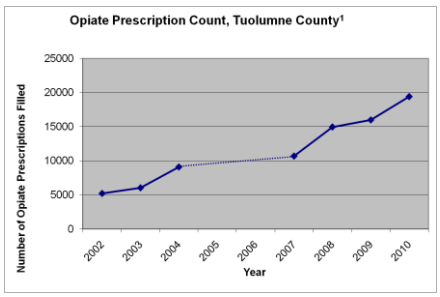
Number of Drug Poisoning Deaths by Type of Drug, California, 2006-2010

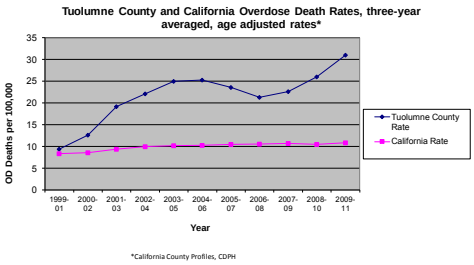
Year	Total Drug Poisoning	All Specific Opioid Poisoning	Opioid analgesics (subset of opioids)	Methadone (subset of opioid analg)	Heroin (subset of opioids)	Sedatives	Amphetamines
2006	3,457	1,470	1178	269	268	343	501
2007	3,792	1,621	1309	303	284	387	471
2008	3,836	1,760	1500	329	317	467	454
2009	4,016	1,954	1692	419	347	510	524
2010	3,942	1,887	1640	451	318	555	559

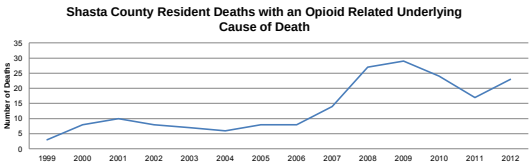


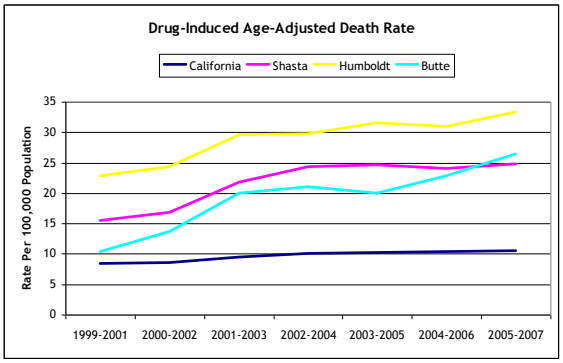
Tuolumne County Overdose Death Data






Tuolumne County and California Overdose Death Rates, three-year averaged, age adjusted rates*
OD Deaths per 100,000
35
30
25
20
15
10
5
0
1999-01
2000-02
2001-03
2002-04
2003-05
2004-06
2005-07
2006-08
2007-09
2008-10
2009-11
Year
Tuolumne County Rate
California Rate
*California County Profiles, CDPH


Shasta County Resident Deaths with an Opioid Related Underlying Cause of Death
Number of Deaths
35
30
25
20
15
10
5
0
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012


Drug-Induced Age-Adjusted Death Rate
California
Shasta
Humboldt
Butte
Rate Per 100,000 Population
35
30
25
20
15
10
5
0
1999-2001
2000-2002
2001-2003
2002-2004
2003-2005
2004-2006
2005-2007

Opioid pain reliever overdose deaths: summary of epidemiology

- Increasing at a faster rate than deaths from any major cause in the United States
- Correlation between opioid prescribing rates and drug overdose death rates
- Patients receiving opioids from multiple prescribers and at high doses at highest risk

California State Government Workgroup

- Established March 2014 and led by CDPH.
  - Department of Health Care Services
  - Department of Justice
  - Medical Board
  - Pharmacy Board
  - Dental Board
  - Department of Education
  - Emergency Medical Services
  - More to be added.

Policy Overview

- CDC and ASTHO have best practices toolkits.
- Governor of Massachusetts outlawed Zohyrdo…went to court and lost.
- Medical Board updated pain mgt guidelines
- Alameda County passed ordinance to force drug companies to pay for collection of unused meds…went to court and won.

Evaluating Risk in Patients on Opioids

Towards a rational approach to opioid management for chronic pain

Andrea Rubinstein, MD
Department of Chronic Pain
Department of Anesthesiology
Kaiser Permanente
Santa Rosa, CA

October 28, 2014

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Disclosure

All persons involved with the planning and presenting of this activity have not had any financial relationships in the past 12 months with any commercial interest or any proprietary entity producing health care goods or services that is relevant to this CME activity.

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Objectives

- Review the current evidence relating to opioid safety and efficacy
- Illustrate some complications and co-morbidities associated with opioid prescribing
- Discuss patient work-up options to ensure medical risk mitigation when prescribing opioids

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Sometimes the treatment *IS* the disease…

"We found a bunch of these clogging your arteries. They're cholesterol pills."

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Case #1: Complex Comorbidities vs. Iatrogenesis Multiforme

- 55 year old man new to KPNC with axial low back pain since 1980's.
- S/P anterior fusion with prosthetic disk 2002, 2006. Constant LBP without radiation.
- New chest wall pain since falling off the toilet. Has difficulty urinating, Disabled, now on SSDI.

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Past Medical History:

- 9 knee surgeries
- Hx of melanoma 1991
- Hx of interstitial nephritis requiring dialysis
- Hx of EtOH abuse, in AA since 1983
- Hx. of abusing Carisoprodol, Diazepam, Codeine, Oxycodone

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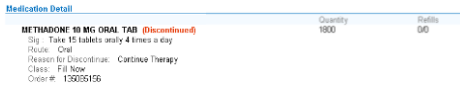
Medications


Medication Detail

	Quantity	Refills
METHADONE 10 MG ORAL TAB (Discontinued)	1800	0/0

Sig: Take 15 tablets orally 4 times a day
Route: Oral
Reason for Discontinue: Continue Therapy
Class: Fill Now
Order #: 136085156

- **2 Years Ago: methadone 40 mg QID**
  - 400% increase in 2 years

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Digression

No evidence of efficacy for opioid medication for axial low back pain past 16 weeks

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Patient Expectations:

47 adults (20 female and 27 male) with chronic low back pain. Pain Res. 2012; 5: 15–22.

PCOQ Domain	Success Criteria	Reduction Obtained
Physical Pain	50.91	11.30
Emotional Distress	34.62	-0.43
Fatigue	40.62	3.89
Interference	49.34	10.04

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Comorbidities:

- Hypertension – HCTZ, metoprolol
- Hyperlipidemia – on simvistatin
- Depression – on citalopram 60 mg PHQ9=19
- No libido and poor sexual function
- Sleep apnea (refusing CPAP)
- Bladder outlet problem – on tamsulosin
- Chronic nausea – on promethazine
- History of melanoma and interstitial nephritis

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Case 1: The Physical Exam

- Alert, oriented and appropriate
- Pale, puffy, slightly feminized features
- Overweight
- Walks with a cane
- Some allodynia generally to light touch
- Examination maneuvers painful
- Exquisitely tender along mid axillary line
- Extreme de-conditioning
- Otherwise unremarkable exam

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The "B.E.S.T" Workup

- Bone Density
- EKG
- Sleep study
  - >75% will have some form of apnea

    Webster, L, et. al. Pain Medicine (2008) 9 425-432
- Testosterone, total AM
  - >50% of all men
  - >70% of men on long-acting opioids

    Rubinstein et. al 2013 Clinical Journal of Pain

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The Workup:

- **469** **Qtc**
- **41** **Total Testosterone**
- **75** **SpO2**
- **-2.4** **T score**

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Digression: QT prolongation

Center for Substance Abuse Treatment Consensus Panel Recommendations:

- **Inform patient of risk**
- **Clinical history**
  - structural heart disease, arrhythmia, and syncope.
- **Obtain EKG**
  - Pretreatment
  - After 30 days
  - Annually
- **More frequent EKG**
  - Dose > 100 mg daily
  - unexplained syncope or seizure
- ***QTc>450 and < 500***
  - *More frequent EKG*
  - *Risks vs. benefits*
- ***QTc> 500***
  - *Discontinuation ?*
  - *Contributing factors?*
  - *Alternative?*
- ***Be aware of interactions between methadone and other drugs***
  - *SSRI, ABX, Psych*

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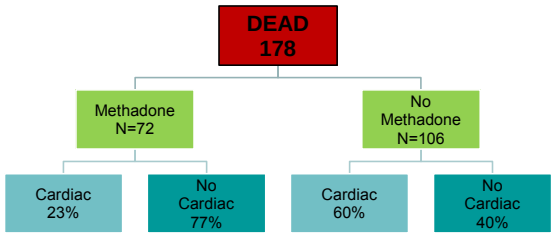
Krantz et. al Annals of Internal Medicine 2008

Implications?



Chugh SS, et.al. *A community-based evaluation of sudden death associated with therapeutic levels of methadone*. Am J Med 2008

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Androgen Deficiency

- Common
- Quick
- Profound
- Reversible
  (usually)

"Low T? How's the rest of my alphabet?"

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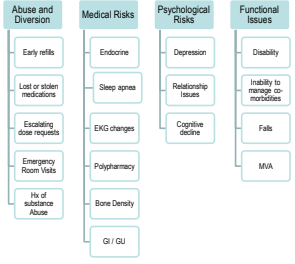
Risk Benefit Analysis



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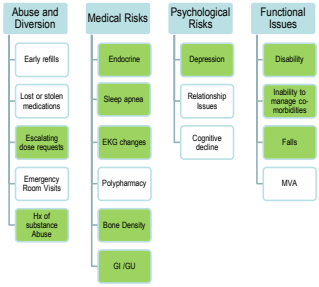
Risk Benefit Analysis



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And of Course…

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The Plan

Taper off methadone

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Tapering Mantra:

What goes up can come down

Opioid withdrawal is not dangerous in healthy patients

KAISER PERMANENTE®

Sobering Statistics

Success rates of tapering off methadone approach zero long term

J Subst. Abuse Treat. 2006 Mar;30(2):159-63.

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The Bottom Line on Tapering

Give them Less Drug

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Case 1 Revisited 6 months later

- Pain is no worse on half the dose (320 mg)
- Feels '100% better' physically
- Emotionally better
- Declined testosterone
- In process of getting CPAP
- QTC = 395
- Actively participating in intermediate pain program

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Case 1 Revisited 2 years later

- Off methadone
- On suboxone 8 mg daily
- No longer needs cane to walk
- Sleep apnea resolved
- Testosterone is 222 ng/dl
- Walking daily for exercise
- Engaging in volunteer work

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Summary of Case 1

- Diagnose co-morbidities
- Weigh risks against benefit
- Fix what you can
- Prevent things from getting worse
- Fear not the taper

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Case 2: Stewed to the Gills
A Case of Hypertrophic Enabling

- 57 y.o. woman with chronic idiopathic pancreatitis causing intermittent severe pain. Was a front office manager at a dental office. She is here today with her father.
- Multiple MVAs since 2007. License revoked. Anxiety, lives with parents. Arm in a cast from a recent wrist fracture after falling off her bike.

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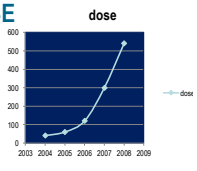
Case 2 Medication History

- 2004 hydrocodone 5/325 6-8 per day = 40 mg MSE
- 2005 oxycodone IR 40 mg = 60 mg MSE
- 2006 OxyContin 80 mg = 120 MSE
- 2007
  - Clonazepam 0.5-1 BID =20-40 mg valium
  - OxyContin 160 mg = MSE= 240
  - Oxycodone IR 40 mg = ms 60
- 2008
  - Clonazepam 2 mg TID (120 mg valium)
  - MS-Contin 180 mg TID (MSE= 540)
  - Amphetamine 10 mg



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Case 2: Warning Signs

- Patient is unable to recall how she takes her medications. Says she is using clonazepam 2 mg 1 per day but refill history shows 3 per day
- No memory of taking 3 per day
- No longer able to work due to cognitive function
- No longer able to drive, DMV revoked license
- Family reports falls asleep, drools, slurs speech

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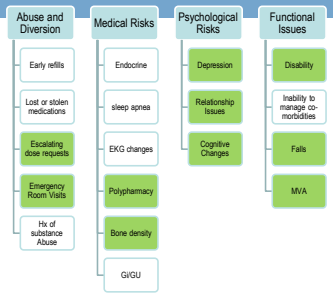
Identifying Clinical Risk of Opioid Use



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Case 2: The Workup

- **Bone density Study:**
  - Osteopenia femoral neck and hip
  - The bone density for the hip has decreased (-8.7%) in 3 years
- **Sleep Study:**
  - Obstructive Sleep Apnea
  - CPAP initiated

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Driving with Sleep Apnea: The Canadian Study

- 783 patients with OSA
- Examined driving records for the 3 years *prior* to polysomnography
- Compared with age matched controls
- 375 crashes over 3 year period
  - 252 in patients
  - 123 in controls
- Very severe crashes
  - 80% were in patients with OSA

Mulgrew, AT et al. Thorax (2008) vol 63:536-541

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Case 2: The Treatment Plan

- Functional goals: ability to drive
- Benzodiazepine taper
- Medication tapering group
  - Can be MD, nurse or pharmacist supervised
- Long term opioid therapy may be necessary

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Case 2: What We Did

- Tapered off benzodiazepines over 4 months
- Self discontinued amphetamine
- Self reduced her morphine to 120 mg daily plus 1-3 Percocet
- Cognition returned to normal
- Able to ride a bike
- Attempting to get driver's license back

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Epilogue

Seen by psychiatrist recently
- Complaining of anxiety

Placed on valium….

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Case 3 Sometimes You Got Bigger Fish to Fry…

- BL is 64 y.o. morbidly obese woman with axial low back pain. Pain is worse with exercise, walking, standing and lying down. Alleviating Factors: "Pain is better with meds."
- Uses Norco 10/325 4 tablets daily
- Also uses alprazolam daily 0.5 mg
- Dose is stable and modestly effective
- Depressed with daily crying
- Very limited function
- DOES NOT WANT TO TAPER

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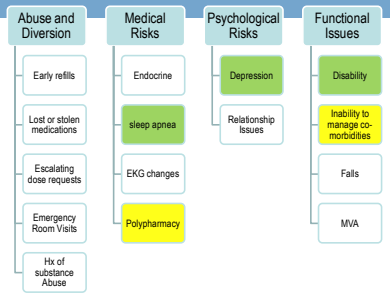
Identifying Clinical Risk of Opioid Use



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Our Plan:

Weight Loss
CPAP

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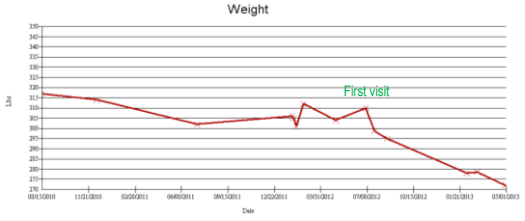
Case 3

Monthly weigh ins:



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Opioid dose the same, Patient is Better

- **> 10% of her body weight (38 lbs.) lost in 9 months.**
  - Reducing diabetes risk > 58%
  - Reduced risk of hypertension
  - Reduced load on knees may be 4 x weight loss

    Messier SP, et. al Weight loss reduces knee-joint loads in overweight and obese older adults with knee osteoarthritis. Arthritis Rheum. 2005 Jul 52(7):2026-32
  - Mood is 100% better
  - Can walk better
- **After almost 2 years, 55 lbs lost**
  - Received hip replacement and dc'd all her medications

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Summary

- The goal is to make the patient better
- Risk benefit assessment is crucial
- Goal is not always off
- Sometimes opioids are not the biggest problem

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We have created diseases in patients that they are unable to appreciate or verbalize. In some cases medications have altered the their ability to make rational decisions regarding the risks and benefits of therapy.

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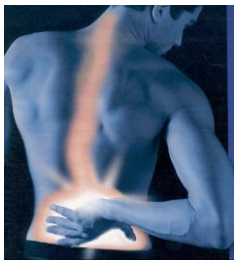
Group Medical Appointment & Functional Restoration Program for Chronic Pain

Michael Amster MD

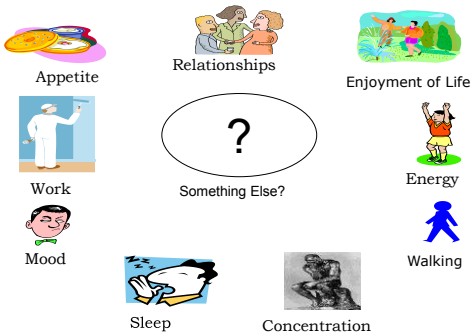
NorthBay Center for Pain Management



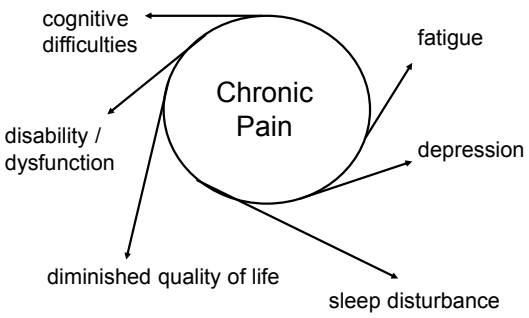
The Chronic Pain Patient

Physician/ Care Provider

Brief Pain Inventory functional areas:



Relationship of Pain and Function



Pain Management Essentials (PME)

- NorthBay Center for Pain Management's chronic pain management functional restoration program
- Based on evidenced programs throughout North America
- Series of 8 group visits, over 8 weeks
- 2 part program
  - Medical and Behavioral (2 ½ hours): Shared Medical Appointments facilitated by physician, pain psychologist and/or nurse practitioner.
  - Mobility (1 ½ hours): Shared physical therapy appointment

PME Program Goals

For patients to:

- Learn and practice self management techniques for chronic pain
- Develop internal locus of control concerning pain.
- Enhance self-efficacy with respect to pain management.
- Decrease controlled substance medication use
- Decrease emergency room visits and inappropriate utilization of medical services

PME Medical / Behavioral Topics

- Education about chronic pain
- Goal setting exercises
- Development of acting coping skills
- Behavioral and lifestyle change skills
- Cognitive restructuring exercises
- Assertiveness training
- Education about psychology co-morbidities
- Relaxation techniques and mindfulness practices
- Sleep hygiene training
- Non-opioid medication management strategies
- Social networking and group support

PME Mobility / PT Topics

- Education about chronic pain
- Goal setting exercises
- Relaxation techniques
- Mindfulness practices
- Qi Gong
- Yoga for chronic pain
- Feldenkrais body awareness
- Posture awareness
- Gait retraining exercises

PME Outcome Measures

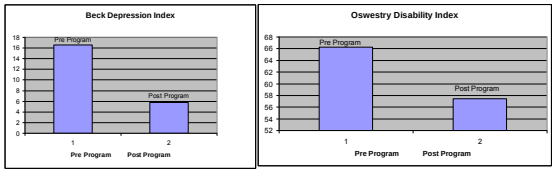
- Oswestry Disability index
- Pain Stages of Change Questionnaire
- Beck Depression Index
- Medication use changes
- Number of visits to the clinic and emergency room before and after the program

PME Outcome Data

- Qualitative:
  - Decrease or elimination of opioids, muscle relaxants and sleep aides.
  - Decrease in number of office visits
  - Increase compliance with prescribed therapies

PME Outcome Data

- Quantitative:



  - Oswestry Disability Index: Pre Program 66 % / Post Program 57% : N= 12
  - Beck Depression Index: Pre Program 16.6 / Post Program 5.8 : N= 12

Group Appointment Challenges

- No show rates (expect 25-50% drop out)
- Time and resource intensive
- Managing difficult patients
- Not everyone is a good fit
- Finding a provider with skill sets to facilitate groups
- Reimbursement challenges

Buprenorphine

Candy Stockton, M.D.

Patient selection

- Patients who are abusing illicit/prescription opiates
- Chronic pain patients who have high levels of physical dependency on prescription opiates but are not exhibiting improvement in their pain or functional status with treatment
- Pregnant women who are opiate dependent

Rationale for Treatment

- Accessibility
- Patient benefits: receiving care at patient's medical home, in conjunction with their other medical care.
- Cost benefits: Buprenorphine adherent patients incurred significantly higher pharmacy charges (adjusted means; $6,156 vs. $3,581), but lower outpatient ($9,288 vs. $14,570), inpatient ($10,982 vs. $26,470), ER ($1,891 vs. $4,439), and total healthcare charges ($28,458 vs. $49,051) compared to non-adherent members. J Subst Abuse Treat. 2014 Apr;46(4):456-62. doi: 10.1016/j.jsat.2013.10.014. Epub 2013 Nov 12. **Relationship between buprenorphine adherence and health service utilization and costs among opioid dependent patients.** Tkacz J[1], Volpicelli J[2], Un H[3], Ruetsch C[4].

Treatment Goals

- Opiate dependence is a temporary state, but addiction is a chronic disease
- Physical stability to improve ability to participate in counseling and behavioral changes.
- Medical risk reduction (communicable diseases, compliance with care for co-morbid conditions)
- Decreased risk of legal problems
- Ability to get treatment while continuing to work

Behavioral Health Component

- You must have established lines of communication.
- Best case scenario-HIPAA makes it difficult to effectively exchange information with outside agencies if you do not have well established relationships.
- Worst case scenario-in my initial group of 10 patients, I had:
  - One patient whose counselor kept cancelling appointments (organization would not confirm or deny this)
  - One patient who was having his mother (not a counselor) forge notes for him
  - One patient (a businessman) whose counselor asked him to join the board for her non-profit. His counseling sessions turned into planning sessions.

Case Studies:

Learning to Redefine Success

Nicky's Story

- I first met Nicky in November of 2012, when she transferred her care to our office.
- She presented with records documenting abdominal pain related to ovarian cysts and was being prescribed Hydrocodone/APAP 10/325, 6 tablets/day.
- She admitted to a remote history of methamphetamine and methadone abuse, had successfully completed treatment through Teen Challenge, and had been sober for 3 years. She denied current substance or alcohol use.

Nicky's Story

- In December, Nicky was admitted to an inpatient treatment program after a suicide attempt (OD)
- Nicky has been on buprenorphine/naloxone treatment since January 2013.
- She has non-prescribed substances on 2 out of 3 drug screens
- She cancels 1 out of 3 of her office and counseling visits on the same day, although she is good about rescheduling
- Is this successful treatment?

The two years before and after treatment started

Before	After
4 Suicide attempts resulting in medical and/or psychiatric hospitalizations	No suicide attempts
Averaged monthly ER visits.	Hospitalized once for a planned gynecologic procedure
Non-compliant with medications for BP and hypothyroidism and gynecologic surgery evaluation	3 ER visits in 20 months
	Compliant with her other medical treatments

V's Story

- V was a cabinet maker before suffering a neck injury 12 years ago. He has had multiple neck surgeries, but still has high pain levels and decreased strength in both upper extremities. He had been on high dose opiates for 10 years and reported 8-9/10 daily pain levels and very limited functionality. He was experiencing dental problems, sedation, constipation, and respiratory suppression (on biPap).

- V attempted to taper off narcotics, but was unable to tolerate significant taper due to pain levels and withdrawal symptoms.
- He successfully transitioned onto Suboxone nine months ago. All of his drug screens have been consistent. He has been compliant with all program requirements.
- He reports that his pain levels are no worse on current treatment. His sedation and cognitive impairment are significantly improved and he proudly notes that family and friends are pointing out the differences in his day to day functioning.

Special Considerations

- Pain control during/after surgical procedures or acute injuries. Make specialists aware of situation and stay connected.
- Stop buprenorphine 48 hours before scheduled surgery and transition onto short acting opiates

R's Story

- R. is a 26 y/o G2P1 female who entered treatment at 18 weeks EGA. She was taking prescription opiates which she was obtaining illicitly, after her prescribing doctor was arrested.
- During treatment, her drug screens were intermittently positive for non-prescribed substances, but she made all her pre-natal appointments

- R's first pregnancy (on methadone maintenance) resulted in a term pregnancy with infant delivered under 6 lbs. The infant developed NAS and was in the hospital around 18 days.
- Her second pregnancy (on buprenorphine) resulted in a term delivery at 6lbs 7oz. He had mild NAS and was discharged after 6 days.
- The average daily cost of neonatal stays is around $3,000 per day (2010). (Cost of Suboxone for entire pregnancy was approx. $3,000). Managed Care Magazine, 2010.

Special Considerations: Pregnancy

- Buprenorphine infants spent a mean of 8.4 days in the hospital compared with 15.7 days for methadone infants
- Only 48.5% of buprenorphine infants required treatment compared with 73.3% of methadone infants.
- Among buprenorphine infants who needed treatment, withdrawal symptoms appeared by day 3 or did not appear at all. Withdrawal symptoms in methadone infants appeared anywhere between days 2 and 6. *[Presentation title: Buprenorphine Versus Methadone Treatment for Opiate Addiction in Pregnancy: An Evaluation of Neonatal Outcomes]Presented by Michael Czerkes,MD at ACOG 58th Annual Clinical Meeting (2010)*

- Shorter length of stay/need for treatment
- Less interruption in family structure
- Theoretical reasoning for changing to buprenorphine mono-therapy during pregnancy

Special Considerations: Lactation

- Serum to breast-milk ratio is 1:1, but the oral bio-availability is low
- Package inserts advise against breast-feeding on Subxone
- Expert opinion supports breast-feeding if no other contraindications exist. They theorize that it might decrease NAS.
  - **Treatment of Opioid Dependent Pregnant Women: Clinical and Research Issues** H.E. Jones, P.R. Martin, S.H. Heil, S.M. Stine, K. Kaltenbach, P. Selby, M.G. Cavalli, K.E. O'Grady, A.M. Arria, and E. Fischer
  - **Gender Issues in the Pharmacotherapy of Opioid-Addicted Women: Buprenorphine** Annemarie Unger, MD, Erika Jung, MD, Bernadette Winklbaur, PhD, and Gabriele Fischer, MD

Getting Started

- DATA 2000: allows qualifying physicians to practice medication-assisted opioid addiction therapy with Schedule III, IV, or V narcotic medications specifically approved by the FDA.
- "Qualifying Physician": has… completed not less than eight hours of training that is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Assn., the American Osteopathic Assn., the American Psychiatric Assn…
- Getting the training: online options
  - http://buprenorphine.samhsa.gov/training_main.html

Getting Started

- Filing for a waiver with SAMHSA
  - http://buprenorphine.samhsa.gov/pls/bwns/waiver
- You must attest to the ability to provide or refer to appropriate counseling services AND the training you completed.
- Connecting with support resources
  - Online discussion board
    - http://bup-webboard.samhsa.gov/login.asp
  - Local providers in your region
    - Mat Ferron, Clinical Liason 2 Opioid Dependency Treatment Advocate [Reckitt Benckiser] (916) 934-9158

Getting Started

- If you practice at more than one site, remember that the 30 (or 100) patient limit is not site-specific.
- You will need to add your "special identification number" to your EHR and controlled scripts.

Experience with Buprenorphine/Naloxone at Open Door Health Center

Dr. Willard Hunter, MD, Medical Director
Open Door Community Health Center

Alternative and Non-pharmacologic Treatment Modalities

Gary Pace MD
October 28, 2014

The Question:

- "If you are going to cut down on my high doses of Morphine, what are you going to replace it with?"

If I, or someone in my family, had chronic pain…

- **I would encourage exploration of alternatives to opioid**s.
- **Western medicine has very little to offer in cases of "chronic low back pain."**
  - High percentage of visits– fifth leading cause of primary care visits, 10 million in 2001 for LBP, (CDC).
  - Meds, PT, epidurals, surgery.
- **Alternative medicine**
  - High patient satisfaction– "A total of 44% had used a CAM during the past year. Increasing age and higher education were significantly associated with CAM use. More than 60% perceived CAM therapy as very effective, and 89% said they would recommend CAM to others. Physicians were unaware of CAM use in 57% of their patients using CAM." *South Med J. 2000;93(4)* .
  - Spending on alternatives-- $34 billion out of pocket on CAM in 2007 (NCCAM).
  - Research--conflicting findings; NIH research-- NCCAM: "We conduct and support research and provide information about complementary health products and practices."

Where is the appropriate place in pain management for the use of alternatives?

- Probably most effective is to use non-opioid, alternative approaches early in the shift as persistent acute pain is moving towards chronic. Rather than ramping up opioids, use some of these other modalities.
- Most alternative practitioners that I know feel they are not too effective with the typical "chronic pain patient" that I see– high opioids, disempowered, on disability, depressed.

Tools that we can consider:

- Therapeutic relationship
- Mind-body connection
- Diet/herbs
- Physical/energetic manipulation

Tools: therapeutic relationship

- Provider relationship
  - extremely important therapeutic modality
  - often gets polarized/dysfunctional in chronic pain patients
  - consider using other structures to set limits with opioid use, in order to protect therapeutic relationship
    - Pain committee
    - Insurance plan
    - Clinic policy
    - other community structures

Tools: therapeutic relationship

- Team approach
  - Get rest of the team very involved in a positive therapeutic relationship with these patients whenever possible
    - MAs
    - Therapists
    - Nurses
    - Groups– peer support

Tools: Mind-body

- Mind-body approaches
  - Don't stop the pain, but change the patient's relationship to the pain
- Dr. John Sarno "The Divided Mind," "Healing Back Pain"
- Dr. Howard Schubiner "Unlearn Your Pain." Schubiner has a decent website. His work is based on Sarno's and may be more accessible.

Tools: Diet/herbs

- Food allergies/anti-inflammatory diet
- The IM4US website has good information on anti-inflammatory and elimination diets.
- Also good information on University of Wisconsin Integrative Medicine Website.

Tools: Diet/herbs

- Western Herbs—
  - anti-inflammatory (Tumeric)
  - specific to pain (California Poppy)
  - Nervines (St John's Wort)
  - Sleep aids– (Hops)
- Local Resources:
  - Farmacopia in Santa Rosa with Lily Mazzarella
  - Rosemary's Garden in Sebastopol
  - California School of Herbal Studies, Forestville.

Tools: physical/energetic manipulation

- -- acupuncture
- -- chiropractic
- -- body workers
- -- mind-body practitioners
- -- OMT
- Learn who is in your community!

How can we have an impact on MediCal patients?

- complex, high-need patient population
- billing/coverage limitations
- packed provider schedules

How can we have an impact on the MediCal population?

- Some things we can do right now in current clinic set-up
  - Provider relationship (as discussed)
  - Team approach (as discussed before)
  - Use of Behavioral Health Providers
  - Osteopaths
  - Physical Therapy referrals

How can we have an impact on the MediCal population?

- Groups
  - Discuss structure a bit (Jeff Geller in Lawrence, MA)
  - Group support—the other patients understand
  - Education
  - Set goals and have accountability
  - Can do prescriptions at the same time
  - Can bring in other types of healers
  - Positive billing structure

How can we have an impact on the MediCal population?

- Chiropractic/Acupuncture
  - was covered until a few years ago.
  - Consider encouraging PHP to open up that coverage again.
  - Some evidence that it can be a helpful treatment for some patients.
  - Many patients feel empowered with these treatments and it helps them get more active.

Provider training

- If providers have a special interest in certain areas, fine to go ahead and get it. I don't think this will significantly impact the issue, though.
- Encourage providers to go and explore other modalities for their own healing, growth.
- Conventional medical providers with a broader perspective can be very valuable in CHC settings in facilitating access to alternative modalities.
- Fellowship at Sutter in Santa Rosa is a local center for Integrative training; also IM4US.

Conclusions and Questions

- Contact: Gary Pace: gpace@alexandervalleyhealthcare.org

Treatment Options for Opioid Addiction

LYNN CAMPANARIO
OCTOBER 2014

Opioid Medications for the Treatment of Pain


Drug Tolerance


Hyperalgesia


Addiction

"Recovery from addiction, a chronic relapse-prone disorder, is a lifelong dynamic process"

A. LESHNER, 1997

Where to start?

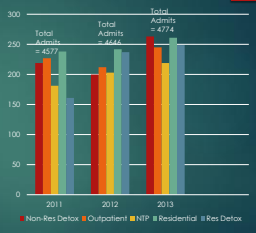
- Complex
- Context
- Withdrawal
- Abstinence-based
- Harm Reduction focus

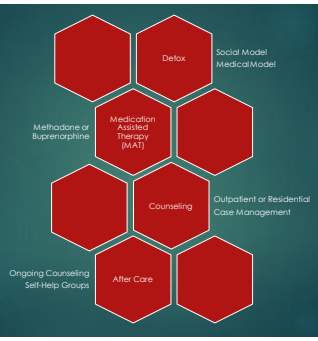
You don't recover by stopping use.

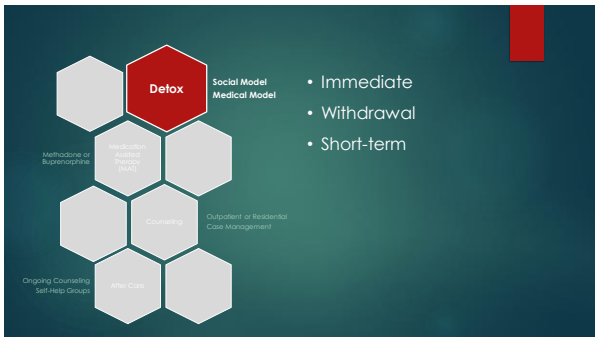
Number of SUDs Treatment Admissions indicating Opiate Use, 2011-13

(CalOMS, Sonoma County)

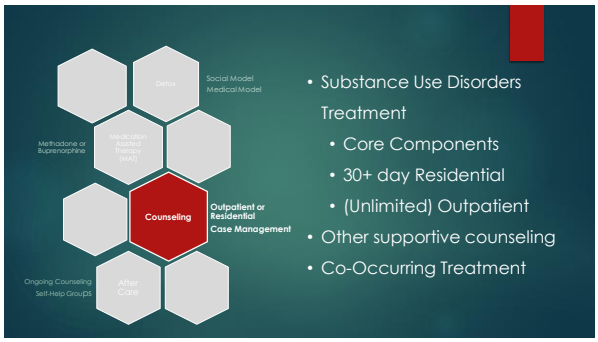
- Treatment Admissions for Opiate use
- Primary Drug of Choice
- Opiate: Methadone, Oxycontin/Oxycodone, Hydrocodone, and Heroin






Detox
Social Model
Medical Model
Methadone or Buprenorphine
Medication Assisted Therapy (MAT)
Counseling
Outpatient or Residential Case Management
Ongoing Counseling Self-Help Groups
After Care
• Immediate
• Withdrawal
• Short-term


Detox
Social Model
Medical Model
Methadone or Buprenorphine
Medication Assisted Therapy (MAT)
Counseling
Outpatient or Residential Case Management
Ongoing Counseling Self-Help Groups
After Care
• Medication + Behavioral Therapies
• Short-term or Maintenance
• Tapering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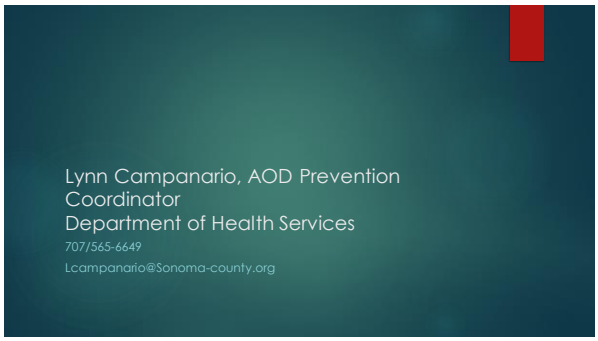
Counseling
Outpatient or Residential
Case Management
Ongoing Counseling Self-Help Groups
After Care
• Substance Use Disorders Treatment
• Core Components
• 30+ day Residential
• (Unlimited) Outpatient
• Other supportive counseling
• Co-Occurring Treatment


Detox
Social Model
Medical Model
Methadone or Buprenorphine
Medication Assisted Therapy (MAT)
Counseling
Outpatient or Residential
Case Management
Ongoing Counseling
Self-Help Groups
After Care
• Relapse Prevention
• Physical Health
• Mental Health
• Housing
• Skill Building
• Peer Support


Components of a Treatment Episode
Intake
ASAM
Assessment
Treatment Planning
Group Counseling
Crisis
Collateral
Discharge Planning
After Care
Referrals


Opportunity
Information Sharing
Integration across modalities
Reduce stigma
Acknowledge the journey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Initiating Successful Patient Conversation

Dr. Andrea Rubinstein, MD, Chief of Pain Management
Kaiser Permanente

Dr. Marie Mulligan, MD, Medical Director
SouthWest Community Health Center

The Art and (very Little) Science of Tapering Opioid Medications

Who, Why, When and How

Andrea Rubinstein, MD
Chief, Department of Chronic Pain
Santa Rosa

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Objectives

- Identify situations when tapering is appropriate
- Learn to design most appropriate type of taper for particular patients
- Gain skills at trouble shooting taper problems to avoid derailing

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Disclosure

All persons involved with the planning and presenting of this activity have not had any financial relationships in the past 12 months with any commercial interest or any proprietary entity producing health care goods or services that is relevant to this CME activity.

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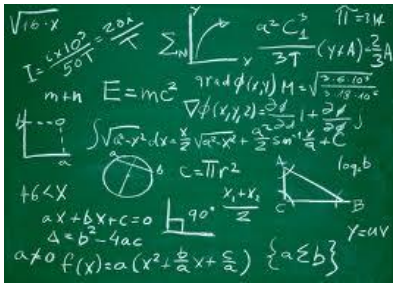
Warning



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What is an Opioid Taper?

A opioid taper is a progressive decrease in the amount of opioid taken

with a goal of leading to reduced risk and or opportunity for greater overall quality of life

for the patient.

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The Bottom Line:

Do not start a medication you do not know how to stop.

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When to Taper

When what the drug is doing TO the patient is more than what the drug is doing FOR the patient.

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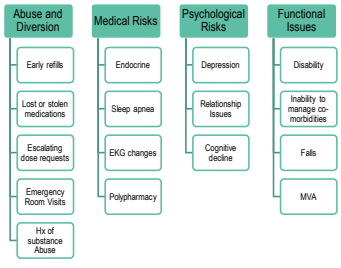
Identifying Clinical Risk of Opioid Use



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Who to Consider for Taper

- Motivated patients
- Young patients
- Patients who say “it’s not working” or “it takes the edge off”
- Patients with diagnosable hyperalgesia
- Patients with declining function despite opioids
- Patients on opioids and complex polypharmacy
- Patients whose underlying pain issue may have resolved

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Who not to taper

- Addicted Patients
- Palliative Care Patients
- Psychiatrically fragile or unstable patients
- Pregnant patients

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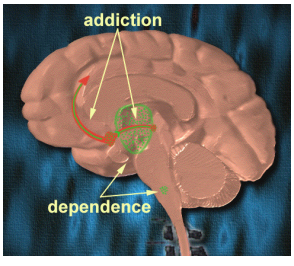
Digression: Dependence vs. Addiction



National Institute of Drug Abuse 2007

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Reasons NOT to not taper

- "It takes the edge off…."
- "I have more pain when I skip a dose so I know it is doing something…"
- "I tried to stop before and my pain got out of control"
- "It is the only thing that lets me work 16 hours per day"
- "I cant figure skate competitively without this"

Opioids are not performance enhancing drugs

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Types of Tapers

- Physician Directed Taper
- Patient Directed Taper
- Rapid Taper
- Group Taper
- Inpatient Taper

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Rules of Thumb for Tapering

1. The longer on opioids the slower you go
2. Medications not used daily can be stopped without a taper
3. Use only one "small currency " opioid
4. Down is easier than off
5. First 1/3 is easier than 2/3
6. Last 1/3 is hard and last 10% is really hard
7. Most patients tolerate 10% reductions
8. Virtually no one tolerates 25% reductions well
9. Going slowly is always better than stopping or giving up
10. The best taper is the one that works

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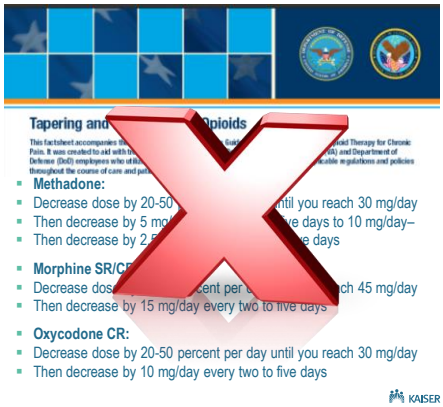

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Case 1 :

- SS is a 46 y.o. male with low back pain/failed back syndrome now with residual axial low back pain and sciatica type pain on the left.
- High dose opioids about 720 mg daily equivalent of morphine dose basically stable since 2007 but vague about his actual daily dose saying "well, it is more than that"
- Recent hospitalized for 11 days for pain control following a fall that broke several ribs. At that time he was also taking Demerol on a "prn" basis. (0-600 mg daily)

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Filtered: Schedule Level (C-II High abuse potential; C-III Moderate dependence; C-IV Limited Depen

Date	AMB/IP	Medication	Order Detail
2/6/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
2/27/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
3/23/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
4/18/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
5/14/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
6/8/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
7/2/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
7/26/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
8/21/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
8/21/2012 (O)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
9/14/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
9/14/2012 (O)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
10/9/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
10/31/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
11/27/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
12/19/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
1/14/2013 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
1/15/2013 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
2/8/2013 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
3/4/2013 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...

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Case 1 SS: risk> benefit

- Moderate obesity
- Function is poor "I just lay on the couch all day"
- Diabetes HgbA1c 9.3
- Testosterone 50ng/dl
- Moderate obstructive sleep apnea
  - Moderate Obstructive Sleep Apnea
    Average Oxygen Saturation: 93%
    Lowest Oxygen Saturation: 83%
- Uses Zolpidem for sleep prn
- Intermittent use of Promethazine or prochlorperazine for nausea of unknown etiology
- Depression on 120 mg daily of Cymbalta

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Taper?

Don't Taper?

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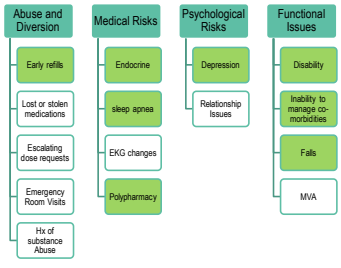
Identifying Clinical Risk of Opioid Use



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STEP 1: The Buy in

- Forwarn
- Option to return
- Reassure
- Educate and Encourage
- Support
- Treatment Plan in Writing

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Physician Directed Taper

Name: SS

DRUG TO TAPER	PILLS SIZE	dosage	# TIMES DAILY	TOTAL DAILY DOSE
MORPHINE	30	8	4	960
	15			

GOAL DOSE	INTERVAL	start date	% reduction min	% reduction maximum
100	1	5/3/2013	5	15

Friday MORPHINE Taper Schedule for SS

date	% drop	Daily mg	#DAY	# RX	mg change
5/3/2013	5	900.0	30.0	210	60.00
5/10/2013	5	855.0	28.5	200	45.00
5/17/2013	5	810.0	27.0	189	45.00
5/24/2013	6	765.0	25.5	179	45.00
5/31/2013	6	720.0	24.0	168	45.00
6/7/2013	6	675.0	22.5	158	45.00
6/14/2013	7	630.0	21.0	147	45.00
6/21/2013	7	585.0	19.5	137	45.00
6/28/2013	8	540.0	18.0	126	45.00
7/5/2013	8	495.0	16.5	116	45.00
7/12/2013	9	450.0	15.0	105	45.00
7/19/2013	10	405.0	13.5	95	45.00
7/26/2013	11	360	12.0	84	45.00
8/2/2013	13	315	10.5	74	45.00
8/9/2013	14	270	9.0	63	45.00
8/16/2013	6	255	8.5	60	15.00
8/23/2013	6	240	8.0	56	15.00
8/30/2013	6	225	7.5	53	15.00
9/6/2013	7	210	7.0	49	15.00
9/13/2013	7	195	6.5	46	15.00
9/20/2013	8	180	6.0	42	15.00
9/27/2013	8	165	5.5	39	15.00
10/4/2013	9	150	5.0	35	15.00
10/11/2013	10	135	4.5	32	15.00
10/18/2013	11	120	4.0	28	15.00
10/25/2013	13	105	3.5	25	15.00
11/1/2013	14	90	3.0	21	15.00
11/8/2013	17	75	2.5	18	15.00

Physician Directed Taper

Name: SS

DRUG TO TAPER	PILLS SIZE	dosage	# TIMES DAILY	TOTAL DAILY DOSE
MORPHINE	30	8	4	960
	15			

GOAL DOSE	INTERVAL	start date	% reduction min	% reduction maxi
0	1	5/3/2013	25	50

Friday MORPHINE Taper Schedule for SS

date	% drop	Daily mg	#DAY	# RX	mg change
5/3/2013	25	720.0	24.0	168	240.00
5/10/2013	25	540.0	18.0	126	180.00
5/17/2013	33	360.0	12.0	84	180.00
5/24/2013	25	270.0	9.0	63	90.00
5/31/2013	33	180.0	6.0	42	90.00
6/7/2013	25	135.0	4.5	32	45.00
6/14/2013	33	90.0	3.0	21	45.00
6/21/2013	33	60.0	2.0	14	30.00
6/28/2013	25	45.0	1.5	11	15.00
7/5/2013	33	30.0	1.0	7	15.00
7/12/2013	50	15.0	0.5	4	15.00
	100	0.0	0.0	0	15.00

Case 1: The Plan

- Discontinue meperidine (no taper)
- Weekly check-ins with our medication nurse
- Taper morphine by 45 mg a week
  - MS IR 30 mg tablets
  - Taper: take 30 tablets daily in 6 divided doses x 7 days (TUESDAY)3/9
  - Taper: take 28.5 tablets daily in 6 divided doses x 7 days (TUESDAY)3/9
  - Taper: take 27 tablets daily in 6 divided doses x 7 days (TUESDAY)3/9
  - Taper: take 25.5 tablets daily in 6 divided doses x 7 days (TUESDAY)3/9
  - Taper: take 24 tablets daily in 6 divided doses x 7 days (TUESDAY)3/9

Withdrawal

Case 1: Follow up

- Seen in office recently on 540 mg Morphine daily (1/3)
- Having difficulty with last taper drop
- 8% dosage drop was hard
- Change dosage drop to 15 mg
  - MS IR 30 mg tablets
- Taper: take 17 1/2 tablets daily in 6 divided doses x 7 days (TUESDAY)
- Taper: take 17 tablets daily in 6 divided doses x 7 days (TUESDAY)
- Taper: take 16 ½ tablets daily in 6 divided doses x 7 days (TUESDAY)
- Taper: take 16 tablets daily in 6 divided doses x 7 days (TUESDAY)

Document so covering partners can follow

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Case 1

- Went through 7 days worth of medications in 3 days
- Offered buprenorphine
- Stabilized on buprenorphine 32 mg per day
- Moderate pain control but “overall I feel much better”

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Case 2:

- KH 33 y.o. woman with deep achy pain from hips to knees. Symptoms began with "sciatica" type symptoms. High functioning, with good efficacy of medications. Now wants to get pregnant but VERY anxious about doing the taper
- Current regimen:
  - Oxycontin 40 BID (120MSE)
  - Norco 10/325 8 tablets daily (80 MSE)
  - Occasional Percocet
- Also uses nortryptiline, tizanidine, bentyl, miralax

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Refill History

Filtered: Schedule Level (C-II High abuse potential; C-III Moderate dependence; C-V Limited abuse pot

Date	AMB/IP	Medication	Order Detail
2/1/2013 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
12/31/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
12/6/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
11/3/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
10/2/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
9/6/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
8/8/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
7/11/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
6/10/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
5/17/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
4/19/2012 (O)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
4/19/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
3/21/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally eve...

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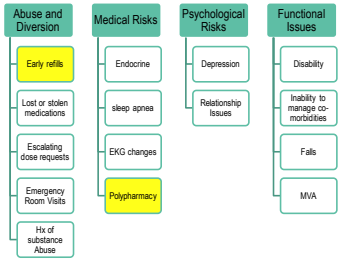
Identifying Clinical Risk of Opioid Use



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Case 2: Patient Directed Taper

- Calculated her oxycodone equivalent
  - Morphine 200 mg = (200)(.75)= 150 oxycodone
- Changed to Oxycodone IR 5 mg tablets
  - Eliminated OxyContin
  - Eliminated Hydrocodone
- Instructions to reduce from 30 tablets per day every few days as she tolerates.
- Weekly check-ins by email or phone
- After 60 days she is on 80 mg oxycodone (50%)
- After 6 months she is on 60 mg oxycodone (60%)
- Pain is the same

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Case 2

- Got pregnant
- Changed to buprenorphine
- Self tapered off buprenorphine during pregnancy
- Delivered healthy baby recently

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Troubleshooting the Taper

- Reassure Reassure Reassure
- Adjuvant medications
  - Clonidine
    - 0.1-0.2 mg BID or TID
  - Immodium
  - Benzodiazepines only at the last 7 days
- Hold or slow the taper at 1/3s
- Watch the clock
- The lower the dose the slower you go
- PAWS

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Buprenorphine

- *If a physician prescribes, dispenses or administers buprenorphine (Suboxone®/Subutex®) for the treatment of pain or for any other reason, a DEA registration is required because both products are Schedule III controlled substances. The DATA waiver specifically authorizes qualified practitioners to treat narcotic dependent patients, using FDA approved Schedule III-V narcotic controlled substances for maintenance and detoxification. The DATA waives the requirement for obtaining a separate DEA registration as a narcotic treatment program for physicians using the approved drugs for maintenance and* detoxification; **however, it does not apply to physicians using Suboxone® or Subutex® for the treatment of pain. A physician using Suboxone® or Subutex® for the treatment of pain would be required to register with DEA as practitioner with Schedule III privileges.**

Sincerely, Patricia M. Good, Chief, Liaison and Policy Section, Office of Diversion Control, Drug Enforcement Administration, U.S. Department of Justice

http://www.helpmegetoffdrugs.com/wst_page9.html

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Summary

- The goal is to make the patient better
- Risk benefit assessment
- Design appropriate taper type
- Modify the taper as appropriate
- Goal is not always off
- Sometimes opioids are not the biggest problem

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Andrea Rubinstein
3559 Roundbarn Blvd
Santa Rosa, CA 95403

andrea.L.rubinstein@kp.org
707-571-3931

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County

MOBILIZING A COMMUNITY

O PREVENT PRESCRIPTION DRUG MISUSE AND AB

County Health Rankings:
Marin Ranks High In Most Indicators

Marin County ranked in the top 5% in:
- Premature death rate
- Adults self reported health
-Mentally unhealthy days
- Adult obesity
- Teen birth rate
- Uninsured adults
- Primary care physicians per capita
- High school graduation
- Unemployment
- Children in poverty
- Physical activity
- Violent crime rate

High food environment index
-Low rate of preventable hospital stays
-Low violent crime rate

Ranked in the top 10% in:
-Low percent of adults reporting fair or poor health
-Low average number of mentally unhealthy days
-High access to exercise opportunities
-High dentists per capita
-High mental health providers per capita
-High percent with some college

Ranked in the top 15% in:
-Low percent of adults who smoke
- Low percent of children in single-parent households
- Low average daily air pollution

Ranked in the top 25% in:
-Low number of physically unhealthy days
- Adults without social/emotional support
- Low percent driving alone to work

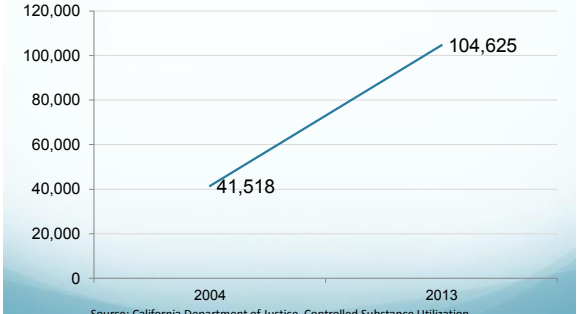
County Health Rankings & Roadmaps
A Healthier Nation, County by County

Marin County ranked in the bottom 50% in:
- [1]Excessive Drinking
- [2]Drug poisoning mortality rate

[1]Data collected from Behavioral Risk Factor Surveillance System 2006-2012 (2005-2010 for social support indicator) and may vary from other local sources used in county health reports and factsheets.
[2]Drug poisoning deaths was an additional measure and did not contribute to the overall county health rankings.

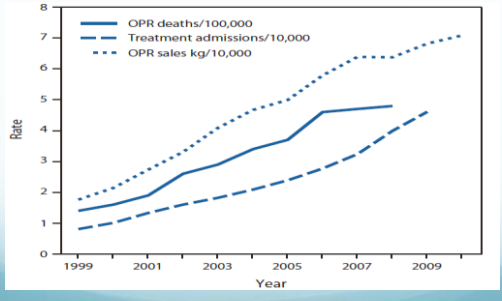
County Health Rankings & Roadmaps
A Healthier Nation, County by County

NUMBER OF SCHEDULE II NARCOTIC PRESCRIPTIONS : MARIN COUNTY, 2004-2013



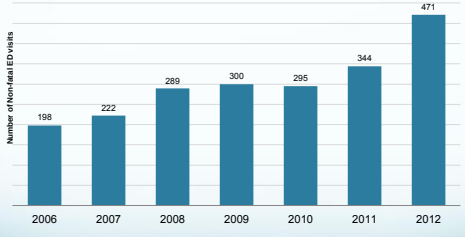
Source: California Department of Justice, Controlled Substance Utilization Review and Evaluation System (CURES)

KILOGRAMS OF OPIOIDS SOLD, OVERDOSE DEATHS AND ADDICTION, U.S. 1999-2010

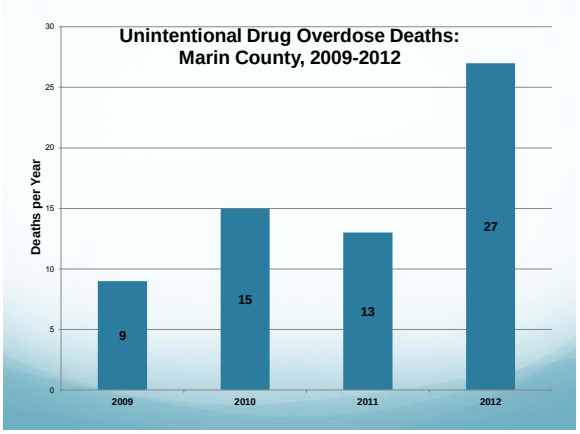


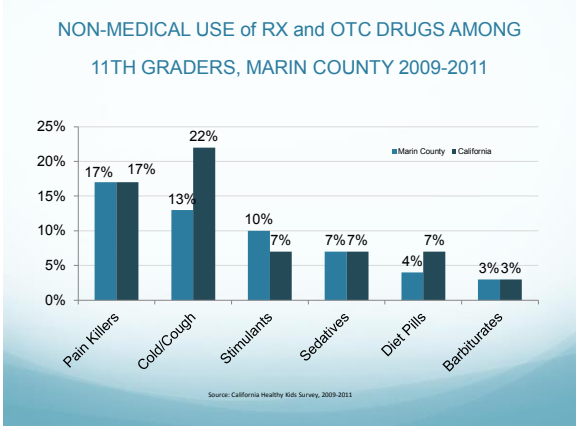
SOURCES: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009 http://www.cdc.gov/vitalsigns/PainkillerOverdoses/index.html

Non-Fatal Emergency Department Opioid-Related Visits: Marin County, 2006-2012



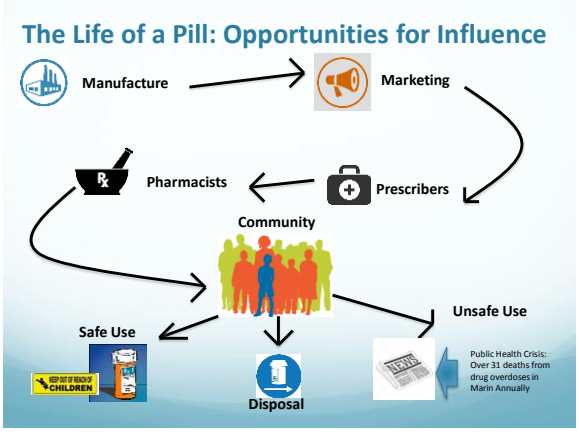
Data Source:
Office of Statewide Health Planning & Development (OSHPD). Emergency Department Data. Prepared by California Department of Public Health, Safe and Active Communities Branch

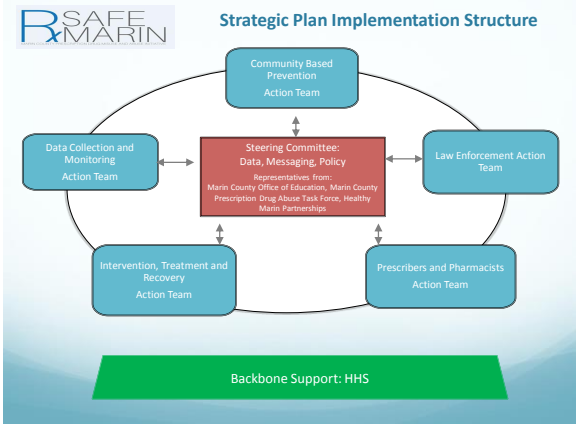

Unintentional Drug Overdose Deaths:
Marin County, 2009-2012
Deaths per Year
30
25
20
15
10
5
0
9
15
13
27
2009
2010
2011
2012


NON-MEDICAL USE of RX and OTC DRUGS AMONG
11TH GRADERS, MARIN COUNTY 2009-2011
25%
20%
15%
10%
5%
0%
Marin County
California
17%
17%
13%
22%
10%
7%
7%
7%
4%
7%
3%
3%
Pain Killers
Cold/Cough
Stimulants
Sedatives
Diet Pills
Barbiturates
Source: California Healthy Kids Survey, 2009-2011


Comprehensive Approach
Prevention
Education
Surveillance
Monitoring
(PDMPs)
Diversion
Control
Law
Enforcement
Licensure
Treatment
Recovery


PRESCRIPTION
DRUG MISUSE &
ABUSE STRATEGIC PLANNING
FEBRUARY 5TH, 2014
7:15AM - 1:00PM
WELCOME
What can we do as a community to prevent and stop prescription drug misuse and abuse and save lives?
SHERATON FOUR POINTS
1010 NORTHGATE DRIVE
SAN RAFAEL 94903


The Life of a Pill: Opportunities for Influence
Manufacture
Marketing
Pharmacists
Prescribers
Community
Safe Use
Unsafe Use
KEEP OUT OF REACH OF CHILDREN
Disposal
Public Health Crisis: Over 31 deaths from drug overdoses in Marin Annually

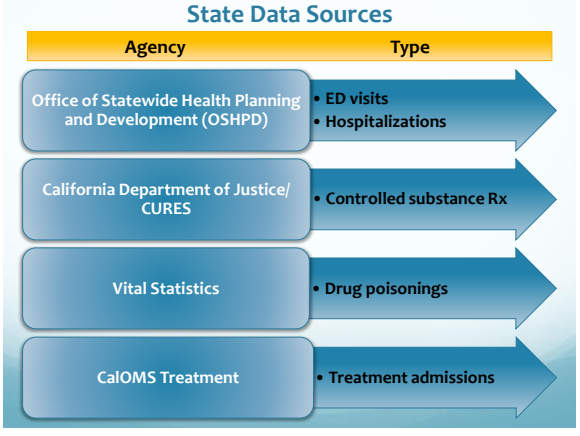

SAFE MARIN
Strategic Plan Implementation Structure
Community Based Prevention Action Team
Data Collection and Monitoring Action Team
Steering Committee: Data, Messaging, Policy
Representatives from: Marin County Office of Education, Marin County Prescription Drug Abuse Task Force, Healthy Marin Partnerships
Law Enforcement Action Team
Intervention, Treatment and Recovery Action Team
Prescribers and Pharmacists Action Team
Backbone Support: HHS

Action Team Example: Data Collection & Monitoring

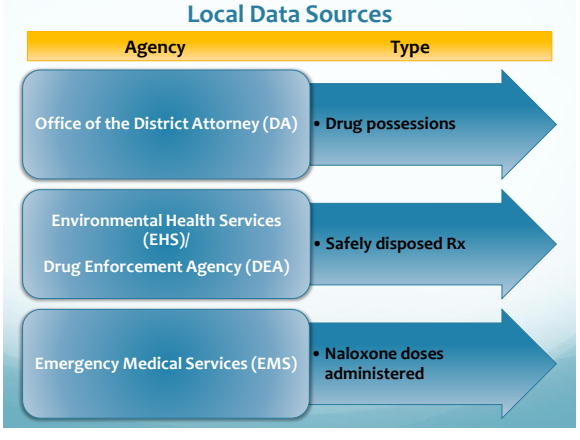
Vision: Marin County will have county-wide relevant data on prescription drug misuse and abuse

- A1: Report card generated and disseminated by December 31, 2014
  - A1i: Identify 5-7 common data pieces for report card
  - A1ii: Complete report card and share with stakeholders

State Data Sources



Local Data Sources



Potential Indicator 2: Non-Fatal Opioid-Related Emergency Department Visits

Why this matters:

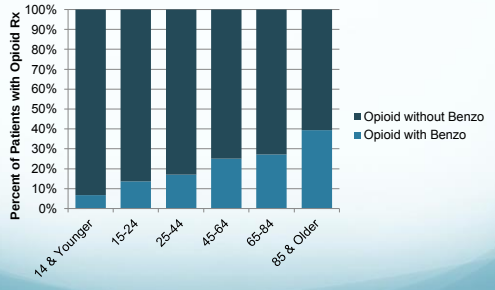
The Centers for Disease Control and Prevention (CDC) reports that in 2011, drug misuse and abuse caused about 2.5 million emergency department (ED) visits. Of these, more than 1.4 million ED visits were related to pharmaceuticals. In the United States, prescription opioid abuse costs were about $55.7 billion in 2007. Of this amount, 46% was attributable to workplace costs (e.g., lost productivity), 45% to healthcare costs (e.g., abuse treatment), and 9% to criminal justice costs.

Report Card Data:

Indicator	2006	2007	2008	2009	2010	2011	2012
Non-Fatal Opioid-Related Emergency Department Visits	198	222	289	300	295	344	471

Data Source:
Office of Statewide Health Planning & Development (OSHPD). Emergency Department Data. Prepared by California Department of Public Health, Safe and Active Communities Branch

Patients Receiving Both Opioid and Benzodiazepine Prescriptions Simultaneously — Marin County, 2010-2013



Potential Indicator 3: Total Number of Prescriptions for Controlled Substances

Why this matters:

The quantity of narcotic prescriptions in a population has been associated with abuse, diversion and overdoses in various populations. Prescriber practices, pharmaceutical companies and patient behavior (such as "doctor shopping") are all factors influencing the quantity of controlled substance prescriptions. This indicator allows us to track controlled substance prescriptions over time.

Report Card Data:

Indicator	2010	2011	2012	2013
Total Number of Prescriptions for Controlled Substances	396,518	403,561	416,777	412,356

Data Source: *Controlled Substance Utilization Review and Evaluation System (CURES), California Prescription Drug Monitoring Program (PDMP)*

RxSafe Marin Report Card: DRAFT

	Data Indicators	2009	2010	2011	2012	2013
1	**Unintentional drug poisoning deaths**	9	15	13	27	
2	**Non-fatal opioid-related emergency department visits**	300	295	344	471	
3	**Student self-report Rx painkiller use**		17%			
4	**Number of controlled substance prescriptions**		396,518	403,561	416,777	412,356
5	**Median number of pills per narcotic prescription**		50	45	50	56
6	**Number of Practitioners and Pharmacists Registered with CURES** •Practitioners •Pharmacists		 54 4	 95 9	 121 11	 149 42
7	**Pounds of safely disposed medications** •Via take back events •Via EHS collection sites	 2,941	 4,638	 390 4,555	 634 5,202	 1,085 6,433
8	**Possession of controlled substance without a prescription**		8	9	13	28
9	**Narcan administrations by Emergency Medical Services (from March 1 through December 31)**					115
10	**Adult treatment admissions (fiscal year, 2009 represents July 2008 - June 2009, etc.)** •Total adult treatment admissions •% of clients reporting opiate use (including heroin) at time of admission		 2,065 29.7%	 1,628 28.5%	 1,399 32.6%	 1,600 32.5%

Action Team Example: Prescribers and Pharmacists

Goal: 15% fewer narcotics will be prescribed in Marin County in 2015, compared to 2013

- 1:All Emergency Departments will have common prescribing standards by December 31, 2014
- 2: All Primary Care clinics will have common prescribing standards by June 30, 2014

SAFE PAIN MEDICINE
PRESCRIBING
IN EMERGENCY DEPARTMENTS

- We care about you. We are committed to treating you safely.
- Pain relief treatment can be complicated. Mistakes or abuse of pain medicine can cause serious health problems and even death.
- Our emergency department is committed to providing safe pain relief options. Many types of pain can be safely and effectively managed without prescription medications.

For your SAFETY, we follow these rules when treating your pain:

1. We look for and treat emergencies. We use our best judgment when treating pain. These recommendations follow legal and ethical advice.
2. You should have only one provider and one pharmacy helping you with chronic pain. We do not usually prescribe pain medication if you already receive pain medicine from another health care provider.
3. If prescription pain medication is needed, we generally only give you a small amount.
4. We do not refill lost or stolen prescriptions. If your prescription is stolen, please contact the police.
5. We do not prescribe long-acting pain medicines: OxyContin, MSContin, Fentanyl (Duragesic), Methadone, Opana ER, Exalgo and others.
6. We do not provide missing doses of Subutex, Suboxone, or Methadone.
7. We do not usually give shots for flare-ups of chronic pain. Medicines taken by mouth may be offered instead.
8. Health care laws, including HIPAA, allow us to ask for your medical records. These laws allow us to share information with other health care providers who are treating you.
9. We may ask you to show a photo ID when you receive a prescription for pain medicines.
10. We use the California Prescription Drug Monitoring Program, called CURES. This statewide computer system tracks narcotic and other controlled substance prescriptions.

If you need help with substance abuse or addiction, call (415) 755-2345 for confidential referral and treatment.

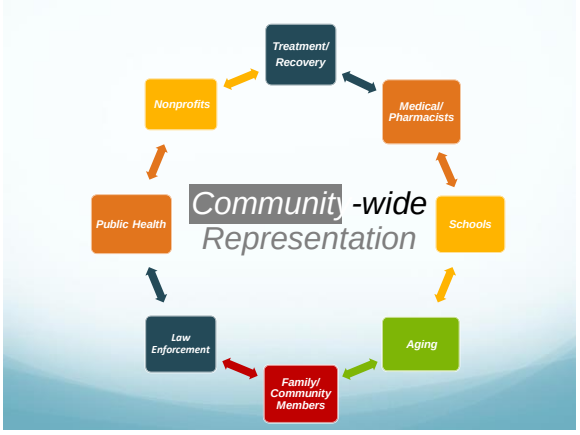
Key elements:

- Community as a "system" with many parts
- Data driven
- New conversations and partnerships
- Centralized support
  - Coordinating and tracking Action Team efforts
  - Cheerleading
- Mutual accountability
  - Tracking progress with established metrics
  - Goals are transparent, measurable and public
- Acknowledge personal and professional dimension
- Political will and support

Thank you

How do we begin?

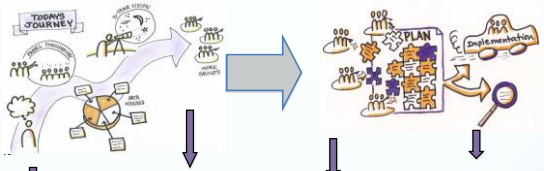
- Approach as a Public Health priority
- Recognize influences are throughout communities:
  - Law enforcement, Prescribers, Pharmacists, Schools, Families, Treatment/recovery, Waste management and others
- Address multiple factors simultaneously and in parallel
- Wide cross sector engagement



Formation of RxSafe Marin

- Prior efforts:
  - Marin County Prescription Drug Abuse Task Force
  - Youth Leadership/Friday Night Live
- Marin County Health and Human Services
  - Mental Health and Substance Use
  - Public Health
- Marin County Office of Education
- HHS funded, facilitated initiative
- Design Team formed Fall 2013
  - Monthly meetings
  - Community Kick-off February 5, 2014

RxSafe Marin: Road Map



Feb 2014

Kick off:
1st Community Wide Meeting

- Reflected on data
- Created our 3 Year Vision
- Workgroups formed

March-May 2014

Workgroups

Part 1
- Identify driving and restraining forces
- Determine Strategic Goals

Part 2
- Asset mapping
- Identify Strategies

June 2014

2nd Community Meeting

- Preview the Strategic Framework
- Identify priorities
- Create 12 month action plans

Current

a.Action Teams
- Determine and carry out first year action plans

b.Steering Committee
- Monitor plan progress
- Media / messaging
- Policy efforts

c.HHS Backbone
- Coordinate logistical support to Implementation Teams and Steering Committee

SAFE Rx MARIN
MARIN COUNTY PRESCRIPTION DRUG MISUSE AND ABUSE INITIATIVE

Community Launch:

MARIN COUNTY PRESCRIPTION DRUG MISUSE AND ABUSE INITIATIVE

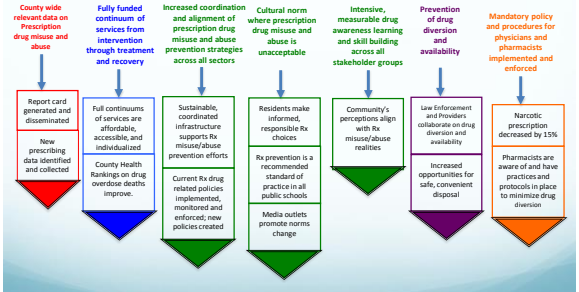
June 19, 2014 / 8:30am-12:30pm

Sponsoring Agencies: Marin Health and Human Services, Healthy Marin Partnership, Marin County Prescription Drug Abuse Task Force, County of Marin

Prepared by: Abinader Group
www.abinadergroup.com

Measurable Strategies and 12-Month Action Plans

In 3 years Marin County will reduce prescription drug misuse and abuse through:



Agenda

Launch Aims:

- Celebrate and share the Strategic Framework
- Invite community input on prioritizing strategic goals and strategies
- Launch the implementation teams and move to action

Breakfast / Networking

Welcome: Moving from Plan to Action

Agenda Review

The Strategic Framework

Walkabout – Preview Strategic Framework

Prioritization and Action Planning: Action Teams

Walkabout - Preview Action Plans

Action Team Accomplishments and Next Steps

Closing Remarks

TEN RULES OF ORDER FOR CENTURY XXI

- Everyone has wisdom to share.
- We need everyone's wisdom for the best result.
- The whole picture comes through hearing and understanding all the perspectives
- There are no wrong answers
- The wisdom of the whole is greater than the sum of its parts
- The more people we engage through participation, the wiser we can all become.
- Participation blows out our images of what is possible.
- People commit to what they create. So the people who implement a plan are the best ones to create the plan.
- Participation in planning creates a sense of self-worth, enthusiasm, respect and accomplishment.

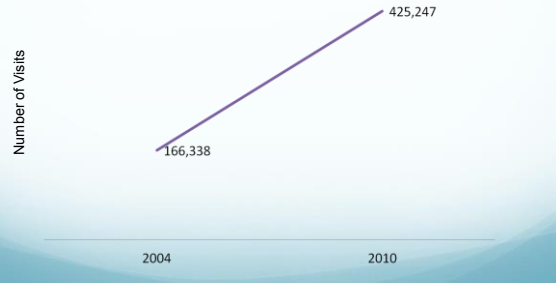
Jo Nelson and Brian Stanfield

ED Prescribing Standards Process

- ED Directors meeting May, 2014
  - Local Data and Evidence presented, discussed
  - Draft guidelines proposed
- Email and phone based co-editing of guidelines
- Adopted and disseminated July 2014
- Public Health Advisory July 10, 2014

Do you know the ER prescribing standards in your county?

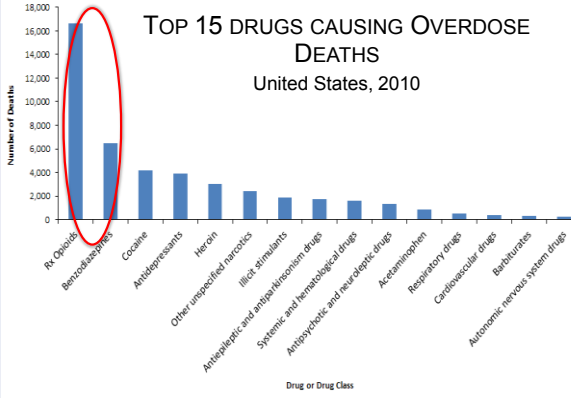
TREND IN ED VISITS FOR NONMEDICAL USE OF NARCOTIC PAIN RELIEVERS, U.S. 2004-2010



Source: SAMHSA Drug Abuse Warning Network (DAWN), 2010

TOP 15 DRUGS CAUSING OVERDOSE DEATHS

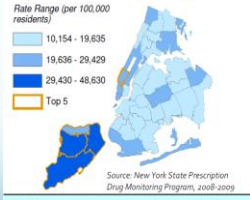
United States, 2010



Jones et al Pharmaceutical overdose deaths, United States, 2010 JAMA 2013 and CDC/NCHS NVSS MCOD 2010.

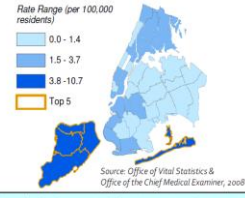
Neighborhoods with Highest Rates of Opioid Prescriptions Also Have the Highest Rates of Overdose Deaths, 2008-2009

Rates of hydrocodone and/or oxycodone prescriptions filled by NYC neighborhood[5]



Source: New York State Prescription Drug Monitoring Program, 2008-2009

Rates of unintentional opioid analgesic poisoning (overdose) deaths by NYC neighborhood[4]

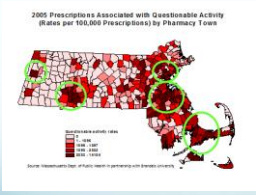


Source: Office of Vital Statistics & Office of the Chief Medical Examiner, 2008-2009

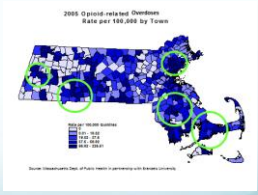
Definitions: The United Hospital Fund (UHF) classifies NYC into 42 neighborhoods, comprised of contiguous zip codes. Income is defined by the percent of households below 200% of the federal poverty level (Census 2000) and separated into three groups: low-income (43%-70%), medium-income (30%-43%) and high-income (13%-30%). To ensure rate stability, two years of prescription and death data were combined for neighborhood analyses.

Source: http://www.nyc.gov/html/doh/downloads/pdf/epi/epi-data-brief.pdf

"Shopping" as a portion of all prescriptions



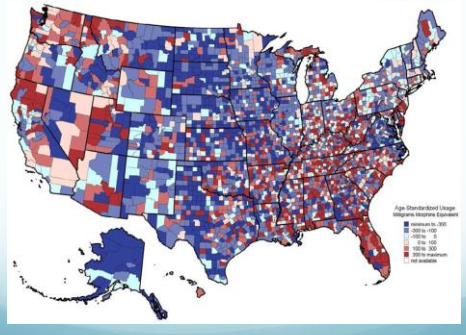
Overdoses in ED Data



Slide provided courtesy of Peter Kreiner, PMP Center of Excellence at Brandeis. Doctor shopping, the questionable activity, was defined as 4+ prescriber s and 4+ pharmacies for CSII in six months.

Source: CDC. Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008. CDC Policy Impact: Prescription Painkiller Overdoses. Available at: www.cdc.gov/homeandrecreationalsafety/rxbrief

Regional Variation in Prescribing Norms



MANAGING PAIN SAFELY FORUM

October 28, 2014

Managing Pain Safely Forum

- **Alexander Gregory Stock - SC186779**
- 2-8 oz bottles of hydromet cough syrup
- 80.6 grams of marijuana in various packages
- 164 vicodin
- 1676 morphine pills
- 1691 Oxycontin pills
- 64 suspected ecstasy pills
- 19.3 grams of cocaine
- 5.3 grams of methamphetamine
- numerous digital scales

Managing Pain Safely Forum

- **Alexander Gregory Stock – SC189152**
- Defendant's vehicle is searched and several bottles of prescription medication are located.
- 2 bottles are in the defendant's name, are for Hydrocodone. One bottle contains 53 and the other contains 40 pills.
- Inside a plastic supermarket bag are an additional 56 loose hydrocodone pills and 1 loose pill inside of a plastic sandwich bag.
- 1 green colored RX bottle is located and appears altered to reflect the defendant's name. It contains 8 additional hydrocodone.

Managing Pain Safely Forum

- **Robert James Grimmer - SC190241**
- Capped and loaded needle on the mattress about 1 foot from RJG. The plunger was pulled back and there was a clear substance in the needle, which was NIK positive for Heroin (32 cc) (HS 11350(a)). Next to the needle was the tip of a rubber glove (cut off to form a rubber sack or bindle) wrapped with a "tie-off" strip of cloth. Inside the rubber bindle was a small, plastic bag containing 22 pills and 24 1/2 pills, which RJG claimed were his prescription Methadone. (CURES confirms def has a Methadone prescription.) Also a plastic baggie .81 g of Meth (NIK positive) (HS 11377(a))

OFFICE OF THE DISTRICT ATTORNEY
MARIN COUNTY, CALIFORNIA
*Prevention * Prosecution * Protection*

Edward S. Berberian
District Attorney

(Date)

*
*
*

Re: Defendant's name; Marin County Superior Court Case No. *A

Dear Physician's Name:

It has come to our attention that * is currently, or was recently a patient of yours.

On *, 2014, a criminal complaint was filed against *, alleging unlawful diversion of prescription drug medication, specifically violations of sections* of the Health and Safety Code, occurring on *. A copy of the Complaint is attached hereto for your reference.

This information is being provided as the result of a partnership between the Marin County District Attorney's Office, Marin Health & Human Services, and Partnership HealthPlan of California. The goal of this partnership is to share information with physicians regarding unlawful prescription drug diversion and misuse, enabling physicians to make informed treatment decisions.

Please do not hesitate to contact our office if you have any questions.

Very truly yours,

EDWARD S. BERBERIAN
DISTRICT ATTORNEY

*
Deputy District Attorney

/

Enclosure

cc: Sean A. Kensinger, Marin County Deputy District Attorney

MAIN OFFICE: 3501 CIVIC CENTER DRIVE, ROOM 130, SAN RAFAEL, CA 94903-4197 TEL: (415) 473-6450 FAX: (415) 473-3179

Managing Pain Safely Forum

- **Contact Information**
- **Ed Berberian**
  - **District Attorney, County of Marin**
  - **Telephone: (415) 473-6450**
  - **Email: eberberian@marincounty.org**

Chronic Pain and Prescription Drug Abuse Project

Humboldt County, CA
Mary Meengs, MD
Medical Director, Humboldt Del Norte IPA

Behind the Redwood Curtain

Humboldt County is…..Remote, sparsely populated, (135K in an area 3X the size of Rhode Island, density 38 persons/sq mi, CA avg is 239), poor, and has no integrated health care system

Diminishing primary care work force (aging out, burning out), a few still in private practices, + large (though still inadequate) safety net clinic system. 3 "pain specialists" provide mostly injections, no integrated pain center, insufficient specialists, no methadone clinic, umpteen different EMRs, one main hospital administered non-locally

Social Determinants of Health

Access to care

Evidence suggests that access to effective and timely primary care has the potential to improve the overall quality of care and help reduce costs. One analysis found that primary care physician supply was associated with improved health outcomes ranging from reduced all-cause, cancer, heart disease, stroke, and infant mortality; a lower prevalence of low birth weight; greater life expectancy; and improved self-rated health. The same analysis also found that each increase of one primary care physician per 10,000 population is associated with a reduction in the average mortality by 5.3%. Another study found that states with a higher ratio of primary care physicians compared to specialists had improved quality and effectiveness of care, as well as lower health care spending than states with a higher ratio of specialists. Interestingly, increasing the supply of specialist physicians does not show lower mortality rates and does not improve the population health of the United States.

	Humboldt County	California
Population to Primary care physician ratio	800:1	631:1
Population to Mental health provider ratio	2,997:1	1,853:1
Uninsured adults	24%	24%
Could not see a doctor due to cost	19%	15%
Median household income (2009)	$23,496	$29,020
Persons below poverty level, pct. (2009)	19%	14.2%

Sources: US Census Bureau State & County Quick Facts (http://quickfacts.census.gov/qfd/index.html); County Health Rankings (http://www.countyhealthrankings.org/health-factors/access-to-care)

What we do have is

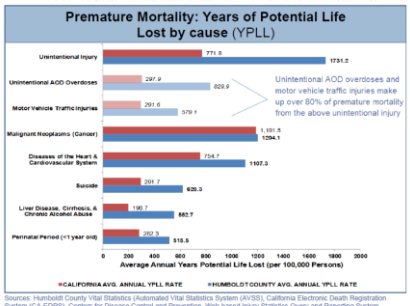
- We know each other and sometimes we play well together
- IPA is convener of twice-monthly Care Improvement meetings, attended by wide representation from community, including Public Health, who presented the
- DHHS Community Health Assessment 2013

Mortality

Life expectancy in the United States is approximately 78 years. Death prior to age 75 is considered premature. As with lifespan, there are a variety of factors that contribute to premature death.

Five of the eight leading causes of premature death are either largely or entirely preventable. These are unintentional injury, alcohol and other drug (AOD) overdoses, motor vehicle traffic injuries, heart disease, suicide, and liver disease/cirrhosis.

The table on the facing page shows how Humboldt County compares to California and the US Healthy People objectives.



Sources: Humboldt County Vital Statistics (Automated Vital Statistics System (AVSS), California Electronic Death Registration System (CA-EDRS), Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WISQARS)(http://www.cdc.gov/injury/wisqars/index.html), National Center for Health Statistics (NCHS) Vital Statistics System, California data covers 2008-2010; Humboldt County data covers 2008-2012.

Alcohol and Other Drug Abuse

Why do rural California counties have consistently higher rates of alcohol and other drug related deaths? There is no single identifiable cause. But there are some shared risk factors that contribute to the problem:

- Isolation can prevent people from forming supportive relationships.
- Geographic distance contributes to transportation barriers and access to basic services.
- Community acceptance and tolerance of heavy drinking and drug misuse creates an environment in which substance abuse and dependence are tolerated.

Rates 2009-2011 unless otherwise noted (per 100,000)	Humboldt				California	+/-	Healthy People 2020 Objective
	Total	+/-	Among Whites	Among Non-Whites*			
Drug induced deaths	36.7	11.6	—	—	10.9	0.4	11.3
Deaths due to unintentional overdose (2008-2012)	27.1	8.8	28.8	26.9	—	—	—
Rate years potential life lost due to unintentional overdose	829.9	49.6	913.6	869.1	297.9	—	—

Sources: County of Humboldt DHHS-PHB—Vital Statistics, CDPH County Health Status Profiles 2013, CDC WISQARS, Healthypeople.gov 2020 Topics and Objectives, California YPLL 2008-2010, Humboldt YPLL 2008-2012. Italics signify that rate is unstable (see Page 10 for explanation).

Even I Can Remember…

- Overdose deaths in Humboldt county have exceeded MV deaths since at least 2005 (probably even longer); this occurred nationally in 2007-8
- Drug induced deaths in Humboldt Co, avg 2009-2011=36.7/100,000. CA: 10.9 over THREE TIMES the state average

So, We Began

- Every other CI meeting focused on our "Chronic Pain" project, where we discussed initiatives from other communities, which led to…
- Large evening meeting Nov, 2013, attended by staff from IPA, Public Health, Partnership Health, clinic administrators and PCPs, pain specialist, dentist, pharmacists, coroners office, county mental health, hospital admin. Presentation of local and national data and summary of successes achieved in other communities and programs in place within our large community clinics. This led to…
- Formation of a Chronic Pain Steering Committee, which developed comprehensive list of important elements, and honed it down to 4 areas to begin with. This led to…
- Formation of small working groups, which are currently still meeting and at various stages of progress

Project Mission Statement

Develop and implement community standards and supporting infrastructure for:

- Diagnosis & treatment for chronic pain, providing patient with optimum care consistent with the risks of the treatment.
- Diagnosis & treatment of acute pain, recognizing the risks of treatment, across providers and settings prescribing opiates.
- Strategies for minimizing misuse and diversion of prescription pain medications.

The context for the project is Humboldt's high rate of patients seeking care for chronic pain, high rate of opiate prescriptions, and high rates of mortality and morbidity relating to drug (often prescription) abuse.

The project recognizes the difficulties faced by patients with chronic pain and by clinicians who must diagnose and treat patients, some of whom intend to misuse prescribed medications, and will strive for balance in this difficult and complex activity.

The key strategy will be to understand the current knowledge about these subjects, developing standards and practical workflow for adoption by all clinicians and settings in the County.

Work Groups

- Data. Public Health leaders & epidemiologist monitor and update pertinent rates, making use of CURES data. They also assist providers will CURES registration and track #s enrolled
- Standards & Guidelines. Develop community standards for assessing and treating pain, and particularly for prescribing opiates. Review guidelines from other organizations to inform. Develop a "toolkit" for prescribers with sample documents and resources.
- Coordination and Communication. Address issues re: poor coordination during transitions of care, from PCP to ED to inpatient/SNF and back to PCP. Use standard care plan and med. contracts and develop ways for these to be shared across locales and providers.
- Pain Boards. Explore development of a specialty multidisciplinary Pain group to whom PCPs could present cases; consider expanding our connection to Project ECHO

2010-2012:

Getting the Word Out

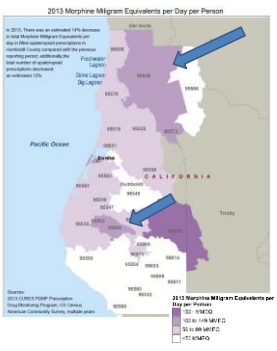
- Articles and emails (Constant Contact)
- REMS presentation by Dr. Cory Waller 5/14 was highly publicized, well attended, and impactful
- Collegial meetings/conversations with providers and clinic staff in “hot spot” areas

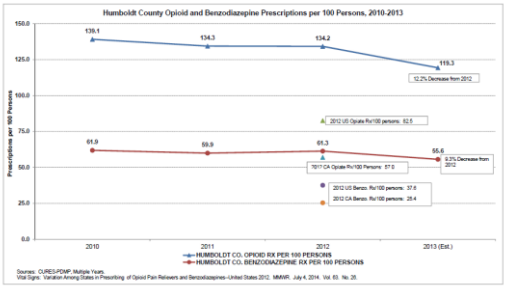
Resources

- Our Pathways to Health, Chronic Pain version
- Shared Decision Making
- Project ECHO

2010-2012:

2013:





Coming Soon

- Marketing/Media/Public Communication work group and campaign
- Inventory of local resources for non-drug treatment of pain---another work group
- More education to providers, including Stanford pain psychologist presenting on Cognitive Behavioral strategies

EARLY EFFORTS: NAPA COUNTY

MANAGING PAIN SAFELY FORUM
ROBERT MOORE
OCTOBER 28, 2014

GETTING STARTED

- Conversations with the Napa Medical Society
- Agreement from PHC to co-sponsor community effort
- Established name for steering group
  - Napa Pain Management Safety
- Scheduled date/venue for initial meetir

ORGANIZING THE INITIAL MEETING

- Enlisted PHC Project Management resources to coordinate initial meeting
- Reviewed materials from Rx Safe Marin kick-off meeting to glean successful practices
- Identified key stakeholders to be part of the Pain Management Safety steering group, which included representatives from:
  - Napa clinics/hospitals
  - Pain specialists
  - Public safety
  - Department of Health
- Prepared agenda and organized seating based on pre-identified work groups
- Invited identified stakeholders

INITIAL MEETING AGENDA

- Brief presentation
  - Historical context
  - The challenges of opioids
  - PHC's activities
  - Successful community efforts
- Table Break-out Activities
  - Creating a Vision for Napa County
  - Brainstorming possible change ideas to attain vision
  - Organizing change ideas into key systems drivers

INITIAL MEETING AGENDA (CONTINUED)

- Formed Action Teams (borrowed from Rx Safe Marin)
  - Community/Communication/Information Sharing
  - Law Enforcement/Public Safety
  - Prescribers/Pharmacists
  - Interventions, Treatment, and Recovery
  - Data Collection and Monitoring
- Identified Action Team leaders and members
- Scheduled initial Action Team meeting

INITIAL MEETING AGENDA (CONTINUED)

- Next Steps Assigned
  - Action Teams meet over the course of 3 months to develop strategies
    - Present change ideas developed during the initial meeting
    - Identify 3 ideas that are doable with the next year
    - Develop a one-year plan regarding those ideas (template provided)
    - Present plan at next Pain Management Safety (scheduled before leaving initial meeting)

EARLY SUCCESSES AND CHALLENGES

- Early Successes
  - Key stakeholder participation
- Challenges
  - Administrative Support
    - Organizing/facilitating meetings
    - Driving action team deliverables

QUESTIONS

Project ECHO for Chronic Pain

October 29, 2014
Robert Moore, MD MPH
Chief Medical Officer

Origins of Project ECHO

Sanjeev Arora, MD
Gastroenterologist
Professor of Medicine
University of New Mexico Health Sciences Center

ECHO: Extension for Community Healthcare Outcomes

Mission

The mission of Project ECHO is to expand the capacity to provide best practice care for common and complex diseases in rural and underserved areas and to monitor outcomes.

First ECHO

- **Hepatitis C**
  - Demand for Consultation exceeded supply
  - Rural State
  - Video conferencing capacity for Tele-medicine
- **Goals**
  - Develop capacity to safely and effectively treat Hep C in all areas of New Mexico and to monitor outcomes
  - Develop a model to treat complex diseases in rural locations and developing countries

Methods

- **Use technology (multipoint videoconferencing and Internet) to leverage scarce healthcare resources**
- **Disease Management Model focused on improving outcomes by reducing variation in processes of care and sharing "best practices"**
- **Case based learning: Co-management of patients with university-based specialists (learning by doing)**
- **HIPAA compliant web-based database to monitor outcomes**

What is Best Practice in Medicine

- **Algorithm**
- **Check Lists**
- **Process**
- **Wisdom based on Experience**

Benefits to Rural Clinicians

- **No cost CMEs and nursing CEUs**
- **Professional interaction with colleagues with similar interest**
  - Less isolation with improved recruitment and retention
- **A mix of work and learning**
- **Access to specialty consultation with team of experts**

From Primary Care site perspective

From University Perspective

Arora S., Kalishman S., Thornton K., Dion D. et al. Hepatology. 2010 Sept;52(3):1124-33

Effectiveness of Project ECHO

TREATMENT OUTCOMES

Outcome	ECHO	UNMH	P-value
	N=261	N=146	
Minority	68%	49%	P<0.01
SVR* (Cure) Genotype 1	50%	46%	NS
SVR* (Cure) Genotype 2/3	70%	71%	NS

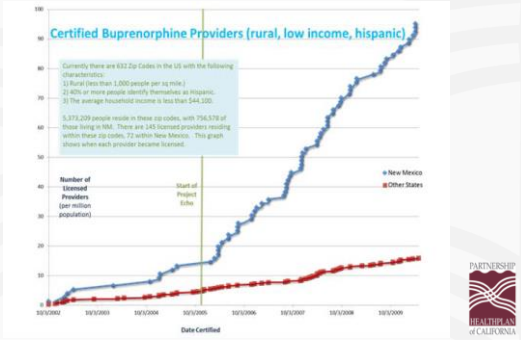
*SVR=sustained viral response

NEJM : 364: 23, June 9-2011, Arora S, Thornton K, Murata G

Conclusions

- Rural primary care Clinicians deliver Hepatitis C care under the aegis of Project ECHO that is as safe and effective as that given in a University clinic
- Project ECHO improves access to hepatitis C care for New Mexico minorities

Project ECHO for Buprenorphine



Summary: Benefits of Project ECHO

- **Increase consistency of high quality care**
- **Rapid learning and best practice dissemination**
- **Increased access for rural and underserved patients**
- **Workforce training and force multiplier**
- **Improved professional satisfaction/retention**
- **Cost effective care, avoiding excessive testing and travel**
- **Prevent health care costs associated from untreated disease**

Project ECHO topics

Medical :

- **Hepatitis C**
- **Chronic Pain**
- **Complex Care**
- **Rheumatology**
- **Geriatric Care**
- **Endocrinology**
- **HIV/AIDS**
- **Palliative Care**
- **Dementia**
- **Women's Health and Genomics**
- **Headache Management**
- **Child and Youth Epilepsy**
- **Cardiovascular health**
- **Congestive Heart Failure**
- **Childhood Obesity**
- **Antibiotic Stewardship**

Behavioral Health:

- **Child and Adolescent Psychiatry**
- **Mental health and addiction**
- **Use of buprenorphine**

Paraprofessional training:

- **Community Health Worker**
- **Substance abuse treatment**

Spread of Project ECHO Model

- **U.S. Department of Defense**
  - Chronic Pain
- **U.S. Veterans Administration**
  - 6 regions; includes chronic pain
- **Seven U.S. Universities**
  - Includes UC Davis pilot
- **Three U.S. Health Systems**
  - Includes LA Net, urban version of ECHO
- **One community health center consortium**
  - Community Health Center, Inc., Connecticut
- **Four other counties**
  - India, Uruguay, Canada, Ireland

UC Davis Chronic Pain ECHO

- **Funded through 2 year grant CHCF**
- **Multidisciplinary team of 7 specialties**
- **75 minute sessions**
- **Didactic presentation coupled with case presentations**
- **Collaborators:**
  - **Partnership HealthPlan of California**
  - **Central California Alliance for Health**
  - **Health Plan of San Joaquin**
  - **California Department of Corrections**

Selected Curriculum Topics

- **Responsible opioid prescribing**
- **Addiction and pain medicine**
- **Headache diagnosis and treatment**
- **Opioid tapering methodologies**
- **Pain and mental health**
- **Pain syndromes and fibromyalgia**
- **The difficult patient**
- **Optimal use of interventional pain modalities**

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Summary

Project Echo

Dr. Willard Hunter, MD, Medical Director
Open Door Community Health Center

Managing Pain Safely
SafeUseNow℠ for PHC

October 28, 2014

Agenda

- Knight News Challenge: Health Overview
- Horizon BCBS NJ Pilot Program Overview
- PHC Program Design
- SafeUseNow Analytics Portal Demo

Knight News Challenge: Health Overview

Section 1

About SafeUseNow℠

- An integrated, actionable solution for systematically and efficiently combating the misuse, abuse, addiction, and diversion of prescription drugs
  - Prescriber ↔ Patient ↔ Pharmacy
- Developed by experts in analytics, optimization, and risk analysis
- One of seven **Knight News Challenge: Health** winners
  - Announced at 2014 Clinton Foundation *Health Matters Conference* in La Quinta, CA
  - Underwrites delivery of SafeUseNow℠ to PHC for one year

Clients & Research Partners

Knight Foundation
Health Data Consortium
Horizon Blue Cross Blue Shield of New Jersey
Pfizer
PURDUE
PARTNERSHIP HEALTHPLAN of CALIFORNIA
PRINCIPLEDstrategies
Source HEALTHCARE ANALYTICS

Pilot Program Overview

with Horizon® Blue Cross Blue Shield of New Jersey

Section 2

Intervention Materials

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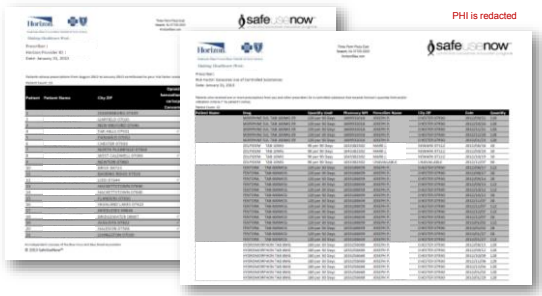
Intervention Materials (continued)



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Outcomes

- Key Statistics
  - Pharmacy savings measurement
    - 1,463,460 claims; 326,754 members; and 99,731 prescribers
    - Results on Slide 6
  - Medical savings measurement
    - Data collection underway
    - Results available late October 2014
- Methodology
  - Population Health Alliance (formerly Care Continuum Alliance) Guidelines Compliant
  - Outcomes co-presented on 4/4/14 in a Continuing Pharmacy Education (CPE) session at the AMCP 26th Annual Meeting & Expo in Tampa, FL

9-Month Post-Intervention Outcomes

Endpoint	Model Significance	P	Savings
Opioid Rx Claims Cost	Yes	= 0.041	$2,596,189
Non-opioid Rx Claims Cost	Yes	= 0.045	$461,731
Total (Annualized)			**$3,057,920**
Benefit-to-Cost			**4.4 : 1**

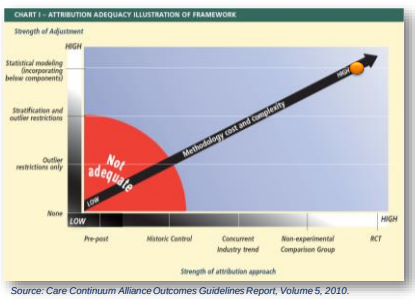
Notes

- Achieved model significance in 4 of 4 risk endpoints: PSI Score™, Multiple Prescribers, Multiple Pharmacies, and Concomitance.
- Achieved model significance in 1 of 2 utilization endpoints: Morphine Equivalent Dose (mg), NOT Opioid Prescription Claims.
- Achieved model significance in 2 of 2 cost endpoints: Opioid Rx Claims and Non-opioid Rx Claims.
- Annualized savings shown based on an assessment of 9-month post-intervention outcomes.

PHC Program Design

Section 3

Randomized Control Trial Methodology



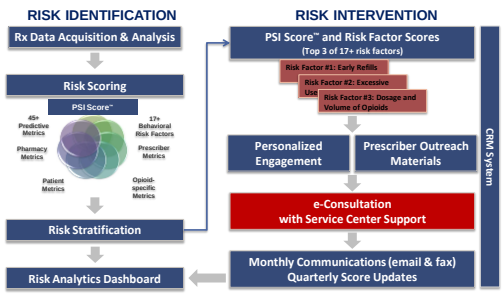
Source: Care Continuum Alliance Outcomes Guidelines Report, Volume 5, 2010.

- **Low** threat to Validity
- **High** complexity

Elements

- Geographic design
  - County-level
- Data
  - 2 years of history
  - Monthly refresh thereafter
    - » Medical and prescription claims
    - » Prescriber demographic
      - Validated physical address, phone, fax or email
    - » Patient demographic
    - » Pharmacy demographic
    - » Drug tables

Key Phases



SafeUseNow Analytics Portal Demo

Section 4

Managing Pain Safely
SafeUseNow℠ for PHC

October 28, 2014

CLOSING REMARKS

MANAGING PAIN SAFELY FORUM
ROBERT MOORE
OCTOBER 28, 2014

SUMMARY OF THE DAY

WHERE DO WE GO FROM HERE?

- Work with your Community
  - Participate in existing community efforts
  - Support or Lead getting new community effort started
- Tapering support
  - Alternative treatment modalities
  - Alternative medications
  - Identifying high-risk prescriber behaviors
    - SafeUseNow
- Resources
  - Toolkit
    - Southern Oregon – Opioid Prescribing Guidelines
  - Recommendations/Guidelines
  - Educational opportunities

CLOSING HOUSEKEEPING ITEMS

- Leave the following on your table or the registration desk:
  - Evaluation
  - Badge

PRESENTER ACKNOWLEDGEMENTS

- Kelly Pfeifer
- Ric Torchon
- Ron Chapman
- Andrea Rubinstein
- Michael Amster
- Candy Stockton
- Willard Hunter
- Gary Pace
- Lynn Campanario
- Matt Willis
- Ed Berberian
- Mary Meengs
- Patrick Burns