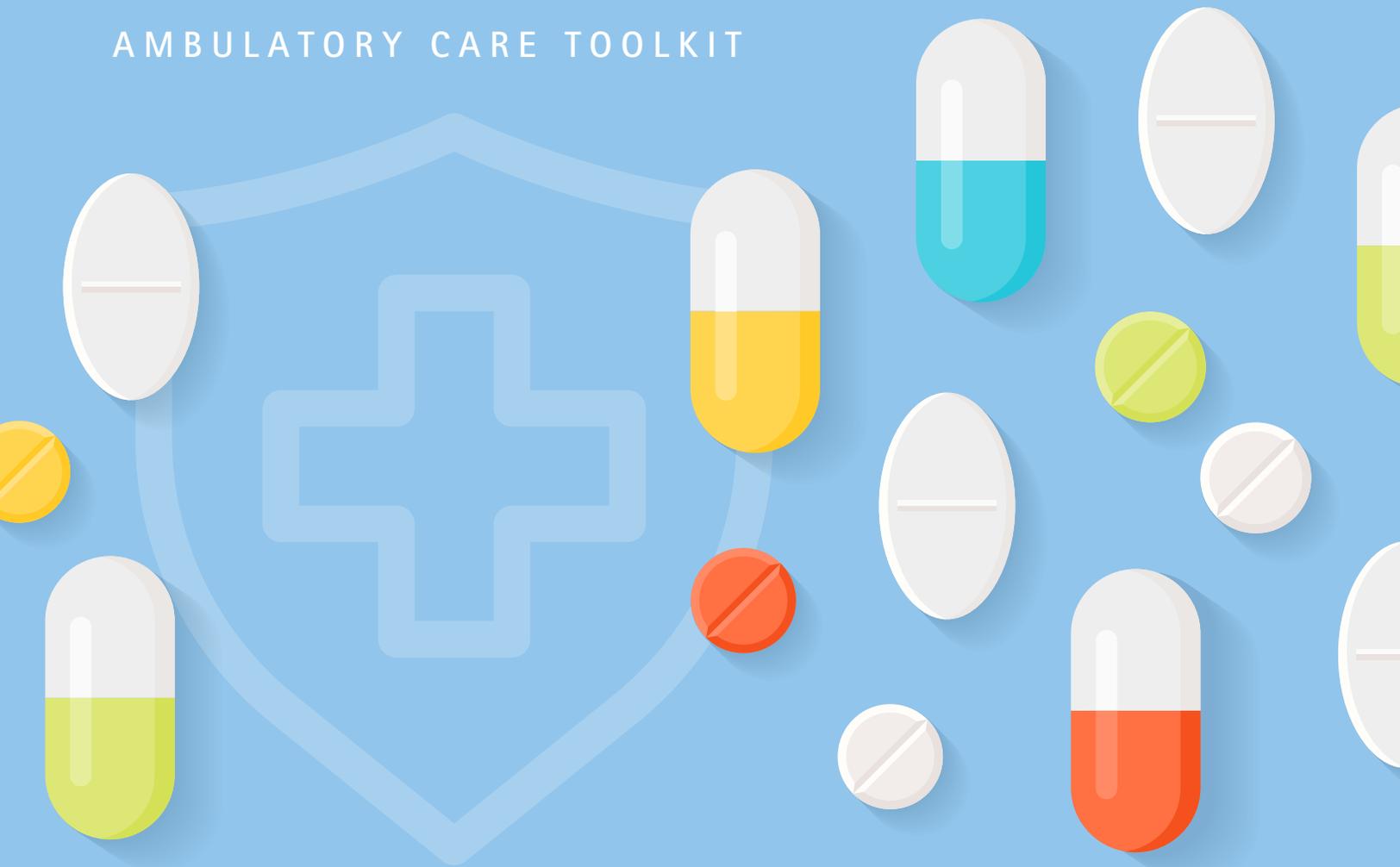


# Accelerating Opioid Safety

AMBULATORY CARE TOOLKIT



## TABLE OF CONTENTS

Introduction	2
Getting Started	4
Strategy: PREVENT	7
Strategy: MANAGE	10
Strategy: TREAT	16
Strategy: STOP	21
Case Study	23
Conclusions	25
Appendix	26
Acknowledgments	39



**CALIFORNIA QUALITY COLLABORATIVE**  
*Breakthroughs for Better Health Care*

IN COLLABORATION WITH



The following document is a guide for provider organizations working to improve opioid safety – to prevent new populations of patients from becoming dependent on or addicted to opioids and improve care for patients with chronic non-cancer pain, opioid use disorder, and/or at risk of overdose. This toolkit summarizes best practices and contains links to resources and tools that you can adapt as you build or test changes for your organization and patients.

---

The ideas suggested in this toolkit were gleaned from a variety of sources:

- Evidence-based practices cited in literature
- Feedback from experts in the field
- Qualitative informant interviews with California health care organizations

Funding for the development of this tool was provided by the California Health Care Foundation in support of Smart Care California's 2019 goal of having every payer (including health plans, purchasers, and risk-bearing provider organizations) launch an organization-wide opioid safety initiative to lower overprescribing (decrease new starts on long-term opioids and more safely manage chronic pain) and reduce opioid-related harm (improve access to addiction treatment and naloxone).

We hope you find this resource helpful. We would appreciate hearing from you about your experience using it. Please contact the California Quality Collaborative with suggestions, comments, or questions by contacting:

Crystal Eubanks  
Senior Manager, Practice Transformation  
[ceubanks@calquality.org](mailto:ceubanks@calquality.org)

If you have received a paper version of this toolkit, please visit our website ([www.calquality.org](http://www.calquality.org)) to download a digital version, which will allow you to access all of the links to the resources within the toolkit.

# Introduction

California Department of Public Health (CDPH) data for 2017 show that while total opioid deaths in California dropped slightly and opioid prescribing declined, fentanyl deaths increased by 57%.

Health care providers in California must learn how to care for the two groups of patients at highest risk of harm: those dependent on high-dose opioids for pain or concurrently on benzodiazepines and those with substance use disorder (SUD). While efforts are in place to lower overprescribing, providers still need to safely and compassionately care for the patients with chronic pain (especially those patients taking high dose opioids and/or concurrent sedatives and wanting safe tapers to lower doses), and those with addiction who need access to effective medications and behavioral treatment. Provider organizations are under substantial pressure to lower overprescribing, safely treat patients with chronic pain on high-risk regimens, integrate medication-assisted treatment (MAT) and addiction services, and coprescribe naloxone to stop overdose deaths. This toolkit can help.



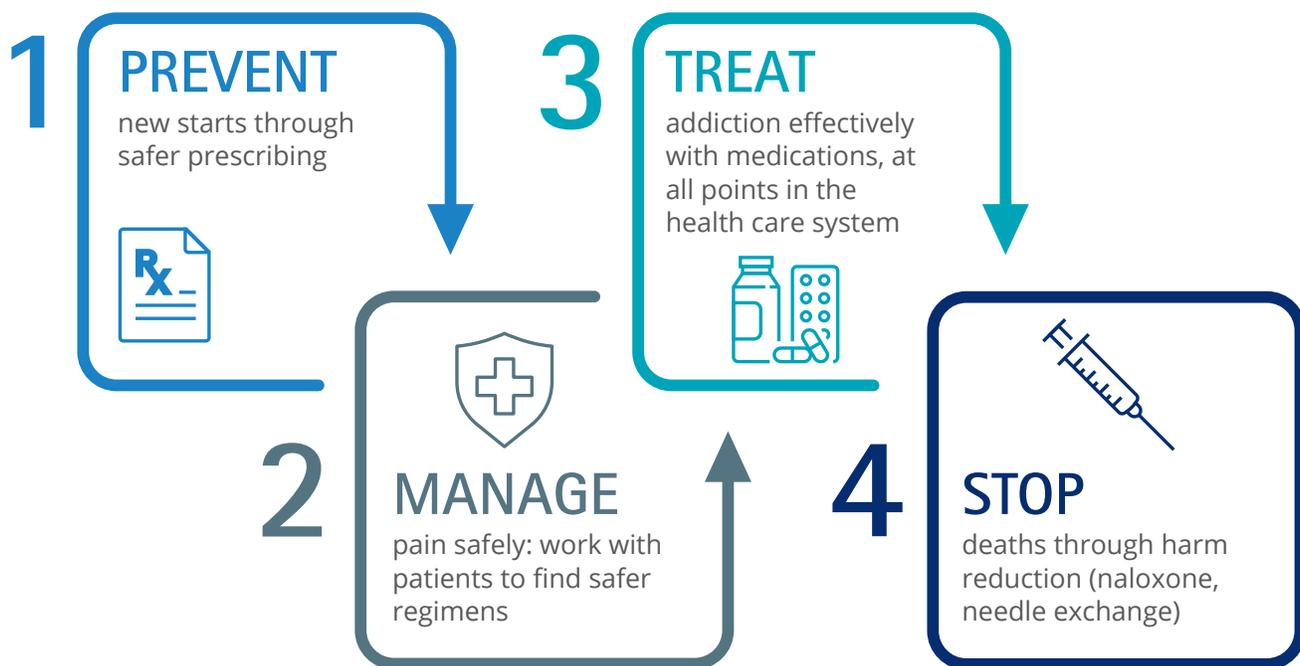
**“We continue to step up our efforts to build a system of care in California where treatment is easier to get than street drugs...**

**We urgently need ‘no wrong door’ access to medication-assisted treatment. It should be accessible wherever people present for care.”**

- Kelly Pfeifer, MD  
Director, High-Value Care  
California Health Care Foundation

# Introduction

## Four Opioid Safety Strategies



### Framework

In alignment with the statewide opioid safety efforts of Smart Care California and the California Health Care Foundation, the toolkit is framed to address four opioid safety strategies: PREVENT new starts, MANAGE pain safely, TREAT addiction, and STOP deaths through harm reduction. Using the [Model for Improvement](#), each strategy is detailed with a description of the aim, related performance measures, and ideas for change with resources in eight change categories: Data/Transparency, Health Information Technology, Workforce Development, Clinical Practice, Leadership, Access to Care, Patient Engagement, and Community Support and Engagement. A summary of change ideas is available in the appendix's Quick Reference Guide. We highlight innovative ideas

within each strategy and include a case study to tell the story of these ideas in action, including lessons learned and ongoing challenges.

Change is hard. Successful and sustainable improvement in opioid safety is no different from any other improvement initiative in requiring patience, a nonjudgmental attitude, and the use of quality improvement tactics like creating improvement teams and doing small tests of change. For guidance on a QI approach to tackling opioid safety, consult the resource [Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain](#).

# Getting Started

## Making the Case

A consistent theme emerged from the organizations interviewed – changing provider behavior and culture is the biggest challenge to improving opioid safety. When making the case for opioid safety improvements to leaders or providers, key messages include:

Efficacy and Joy in Work	Values	Strategic Alignment and Business Case
<ul style="list-style-type: none"><li>▶ The population of patients affected by opioids is creating chaos in the clinic because we are treating them like they have an incurable chronic disease – primary care providers and staff are burning out. Using a different approach will reduce care team burden and burnout and help us retain staff while also improving patient phone and appointment access.</li><li>▶ <u>Reducing opioids is not associated with lower patient satisfaction scores.</u></li><li>▶ Care teams can again find joy in their work because it is rewarding and joyful to see the positive impact on a family, not just an individual. Caring for patients working toward recovery improves employee satisfaction and gives everyone a sense of accomplishment.</li><li>▶ Don't be afraid – just jump in. We have to start somewhere. Taking a step forward does not mean we need to have every step in place.</li></ul>	<ul style="list-style-type: none"><li>▶ We cannot say we are doing no harm. We must stop contributing to the problem.</li><li>▶ Addiction care should be integrated into medical care. We have a duty to treat the whole person.</li><li>▶ The epidemic is affecting and harming everyone – patients, providers, staff, organizations. Providers are overwhelmed with chronic pain patients and managing opioids, patients feel overwhelmed with chronic pain and managing their lives – this improvement work will reduce the tension all around.</li><li>▶ How do we afford it? We make financial sacrifices in other areas to have the resources for opioid safety because it is the right thing to do.</li></ul>	<ul style="list-style-type: none"><li>▶ Improving opioid safety will also help us reach other organizational goals related to improving chronic disease outcomes and decreasing emergency department (ED) use, inpatient admissions, and re-admissions.</li><li>▶ There is a business case with return on investment to be made based on the impact of reducing hospital utilization among chronic pain patients and opioid users and improving access for all patients.</li></ul>

# Getting Started

## Implementing Multi-Year Initiatives

Organizations shared common paths on their opioid safety improvement journeys. While they started with a few passionate people piloting small changes, the intention behind their initial changes was the start of a multi-year initiative. **Leadership support** was necessary to get going, and the passionate people engaged leadership early. There was not usually a clear plan at the beginning, but the key to getting provider buy-in more quickly at the formal initiative launch was a plan detailing the organization's direction. The critical element to getting a plan in place was **convening a multidisciplinary group** of like-minded clinical and operations staff to leverage expertise, perspective, and resources across the organization. Finding multiple champions with energy, knowledge, and time to commit was instrumental in catalyzing the work because they could carve out pieces for each person, making it more doable and organized. Champions took advantage of existing external resources to accelerate efforts. Before a full infrastructure was in place, clinicians ready to innovate were encouraged to undertake Plan-Do-Study-Act cycles and serve as role models.

**Just do it.**

**Take a step forward —**

**You don't need to have every step in place.**

**Take the leap.**

Most initiatives initially focused on safer prescribing and used data, guideline education, and health information technology tools to **standardize provider prescribing of opioids for new starts ("opioid-naïve") at safe doses**. Organizational data and state and county benchmarks, including the [California Opioid Overdose Surveillance Dashboard](#), were used to demonstrate the problem and its scale. Then organizations disseminated provider education tools recommending alternative therapies for pain management and prescriptions for opioids only when appropriate and at safer doses. As the organization worked to increase adoption of standard practices, performance data and patient lists were shared transparently and regularly with providers.

### Steps to Success

**1** Encourage passionate people to pilot small changes

**2** Obtain leadership support

**3** Convene a multi-stakeholder group

**4** Standardize provider prescribing of opioids for new starts and safe tapers

**5** Monitor and support prescribing compliance with guidelines

**6** Expand safe prescribing to other drug types and medication combinations

**7** Increase access to addiction treatment

# Getting Started

The next phase of improvement efforts focused on **monitoring and supporting prescribing compliance with guidelines**. Internal data were used to evaluate the effectiveness of the program so the organization could adjust its methods and communicate progress. Improvement coaches were deployed to practices to ensure consistent adherence to policies and guidelines, as well as one-to-one conversations between clinical leadership and outlier providers. In order for providers to significantly reduce both new starts and taper safely to lower doses, organizations found that they had to offer more alternatives to chronic pain management, including comprehensive programs for patients to address behavioral and physical health. Organizations offered system-wide provider training on patient-centered strategies for tapering to lower doses, and trained staff to build team-based opioid management. A subsequent phase involved **expanding safe prescribing to other drug types and medication combinations**, such as carisoprodol, fentanyl, tramadol, and benzodiazepines. In parallel, clinical guidelines for prescribing naloxone were introduced.

Mature safety initiatives shifted to increasing access to addiction treatment. First steps included increasing the number of x-waivered clinicians and then providing mentoring and peer support to help them feel confident in prescribing MAT. Often, clinics started with one or two clinicians treating only a few patients. As more clinicians became comfortable with prescribing buprenorphine, organizations developed comprehensive MAT programs with multidisciplinary staff and defined care pathways based on patient risk and need. Additional providers became interested in participating as they witnessed their peers finding the work to be rewarding. Effective MAT programs consistently share that collaboration with community coalitions is critical to expanding patient resources and addressing stigma. The vanguard programs are now working on building new reimbursement mechanisms as they scale up their programs to reach more patients. They are focused on identifying outcome measures for MAT programs, piloting alternative payment models to cover gaps between service costs and billing revenue, and hiring and retaining trained staff.

## Foundational resources

- » [CDC Guideline for Prescribing Opioids for Chronic Pain](#) (These apply to new starts, not to tapers to lower doses.)
- » [Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain](#)
- » [CDPH Prescription Drug Overdose Prevention Initiative: "Resources for Opioid Prescribers"](#)
- » [California Health Care Foundation: Opioid Safety and Opioid Safety Resource Catalog](#)
- » [California Opioid Overdose Surveillance Dashboard](#)
- » [California Opioid Safety Network of Coalitions](#)
- » [Smart Care California: Reducing Opioid-Related Morbidity and Mortality: Provider Strategies](#)



STRATEGY **ONE**

# PREVENT

## What are we trying to accomplish?

Lower overprescribing, including decreasing the number of new starts on long-term opioids (fewer prescriptions, lower doses, and shorter durations) and more safely managing chronic pain.

## How will we know a change is an improvement?

### Impact

Reduce new start opioid prescriptions

### Measure

- ✔ Percent of patients with acute low back pain prescribed opioids
- ✔ Percent of patients with opioid prescriptions with no opioid utilization in the prior 90 days

## What changes can we make that will result in improvement?

Change Category	Change Ideas	Resources
<b>Data / Transparency</b>	<ul style="list-style-type: none"> <li>» Review county-level data for prescription rates and opioid-naïve residents with long-acting opioid prescriptions.</li> <li>» Monitor and share data on prescribing rates and utilization of alternative therapies.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">California Opioid Overdose Surveillance Dashboard</a></li> </ul>
<b>Health Information Technology</b>	<ul style="list-style-type: none"> <li>» Create electronic health record (EHR) visit template for pain management.</li> <li>» Integrate pain assessment tools.</li> <li>» Add patient materials for pain management and therapies.</li> <li>» Develop a registry of patients managing chronic pain.</li> <li>» Selectively build in decision support to guide safer prescribing.</li> </ul>	<ul style="list-style-type: none"> <li>» See appendix for a resource list of assessment tools and sources of patient materials.</li> </ul>
<b>Workforce</b>	<ul style="list-style-type: none"> <li>» Disseminate education and training resources to providers for appropriate opioid prescribing and non-opioid pain treatments</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">CDC Guideline Resources and Clinical Tools</a></li> <li>» <a href="#">Alameda County Prescriber Toolkit</a></li> </ul>

# Strategy One: Prevent



Change Category	Change Ideas	Resources
<b>Clinical Practice</b>	<ul style="list-style-type: none"> <li>» Adopt organization-wide standardized guidelines and workflows for pain management and appropriate opioid prescribing, including for specific populations and settings (adolescents, pregnant women, urgent care, and specialties).</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">CDC Guideline for Prescribing Opioids for Chronic Pain</a></li> <li>» <a href="#">Example Workflows for Adult and Family Medicine</a></li> </ul>
<b>Leadership</b>	<ul style="list-style-type: none"> <li>» Identify clinical champions to lead work in opioid safety.</li> <li>» Convene a steering committee of multiple disciplines and functions, including behavioral health.</li> <li>» Develop an incremental opioid safety plan, working with staff and providers to get buy-in.</li> <li>» Create a business case: ensure changes are financially sustainable, look for funding opportunities for start-up costs, and identify reimbursement strategies for long-term.</li> <li>» Participate in health plan committees related to opioid safety (e.g. pharmacy and therapeutics, quality improvement): give feedback, influence policies, and bring back information to your organization.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">Doctors Are Changing San Diego's Opioid Prescribing Practices</a></li> <li>» <a href="#">Safer and More Appropriate Opioid Prescribing: Kaiser Permanente – Southern California's Comprehensive Approach and Research</a></li> <li>» <a href="#">Managing Pain During an Opioid Epidemic – Kaiser Permanente National</a></li> </ul>
<b>Access to Care</b>	<ul style="list-style-type: none"> <li>» Identify access points for alternative pain management.</li> <li>» Offer group medical visits for chronic pain management.</li> <li>» Work with health plan, local coalition, and community to identify behavioral health specialists, evidence-based pain specialists, and SUD treatment resources.</li> <li>» Develop chronic pain management service packages, integrating evidence-based alternative pain management therapies.</li> </ul>	
<b>Patient Engagement</b>	<ul style="list-style-type: none"> <li>» Build workflows to allow easy access to patient materials about pain management and alternative therapies.</li> <li>» Distribute patient-centered materials to support patients in managing chronic pain.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">DiPi Design – Pain Project Materials</a></li> <li>» <a href="#">Opioids: What you need to know (infographic)</a></li> </ul>
<b>Community Support and Engagement</b>	<ul style="list-style-type: none"> <li>» Get involved with your local opioid safety coalition.</li> <li>» Work with local hospital on safer prescribing (e.g. through ED or hospital discharge).</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">California Opioid Safety Network of Coalitions</a></li> </ul>



# Strategy One: Prevent

## INNOVATIVE IDEAS

### Shared decision making tools for chronic pain management

In partnership with the UC Davis Center for Design in the Public Interest (DiPi), Hill Country Health and Wellness Center in Shasta County designed new participatory patient tools “to invite discussion, create awareness, encourage questions, build trust, and work toward better health outcomes through shared decision making and more effective doctor-patient communication.” [DiPi Design — Pain Project](#) offers a variety of patient-centered, open-source materials for adaptation to local patient and provider needs.

**New Patient Pain Treatment Packet** — Friendly, welcoming comic book outlining patient expectations and the philosophy and logistics of treating chronic pain at Hill Country clinics.

**Alternative Treatments Poster and Companion Card Deck** — Introduces patients to a variety of non-medication options for treating chronic pain.

**Controlled Substance and Wellness Agreement (CSWA)** — A very different version of the traditional patient-prescriber agreement, this tool is designed to help patients slow down, reflect, and record questions and notes to discuss with their provider, written in plain language with a welcoming tone.

**Introduction to Opioids Patient Booklet and Video** — Covers important topics related to opioid risks, safety, and prescribing policies.

**Outpatient Radio** — A participatory community radio show produced in collaboration with Hill Country. Weaving together the stories of eight chronic pain patients, the program explores ways to help patients and communities talk about chronic pain and chronic pain treatment.





## STRATEGY TWO

# MANAGE

### What are we trying to accomplish?

Reduce opioid-related harm by working with patients on risky regimens (high-dose opioids, or opioids and sedatives) and support tapering to safer doses, where medically indicated.

### How will we know a change is an improvement?

Impact	Measure
Decrease number of patients prescribed opioids from escalating to unsafe dosage	<ul style="list-style-type: none"><li>✔ Percent of patients with opioid prescriptions in the measurement period whose dosage increased from the prescribed dosage in the 90 days before the first day of the measurement period</li></ul>
Decrease number of patients prescribed unsafe regimens	<ul style="list-style-type: none"><li>✔ Number of patients per 1,000 prescribed daily opioids for longer than 30 days</li><li>✔ Percent of patients on more than 90 MME daily (for more than 30 days)</li><li>✔ Percent or number of patients per 1,000 simultaneously prescribed opioids and benzodiazepines</li><li>✔ Percent of patients on more than 90 MME</li></ul>
Identify opioid use disorder; provide appropriate treatment	<ul style="list-style-type: none"><li>✔ Percent of patients with documented opioid use/prescriptions who have appropriate urine drug screening results</li><li>✔ Number of patients with four or more prescribers or pharmacies</li><li>✔ Percent of patients on chronic opioid therapy who have been screened for substance use disorder</li></ul>
Reduce inappropriate ED use	<ul style="list-style-type: none"><li>✔ Percent of nonfatal opioid overdoses in the ED</li></ul>
Decrease number of patients with addiction	<ul style="list-style-type: none"><li>✔ Number of patients diagnosed with opioid use disorder (OUD)</li></ul>

# Strategy Two: Manage



What changes can we make that will result in improvement?		
Change Category	Change Ideas	Resources
<b>Data / Transparency</b>	<ul style="list-style-type: none"> <li>» Review county-level data for MME levels, multiple medications, and multiple prescribers.</li> <li>» Extract EHR data to provide monthly provider feedback on performance, adherence to prescribing guidelines, and lists of patients at risk, including high doses and/or multiple medications, such as benzodiazepine or carisoprodol.</li> <li>» Monitor and share data on adoption of prescribing guidelines and substance use disorder screening for peer benchmarking. Adjust for panel sizes or exclude specific specialties as applicable.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">California Opioid Overdose Surveillance Dashboard</a></li> </ul>
<b>Health Information Technology</b>	<ul style="list-style-type: none"> <li>» Create EHR alerts for:                             <ul style="list-style-type: none"> <li>+ Prescribing outside of clinical guidelines</li> <li>+ High doses for new starts</li> <li>+ Concurrent prescription of benzodiazepines and opioids</li> <li>+ Checking the Controlled Substance Utilization, Review and Evaluation Systems (CURES) every four months, and for initial prescriptions</li> </ul> </li> <li>» Create EHR visit templates for taper plans and pain monitoring with treatment outcomes.</li> <li>» Add patient educational materials about opioids and appropriate use.</li> <li>» Deactivate specific unsafe medications in the EHR formulary, including carisoprodol and oxymorphone ER.</li> <li>» Integrate screening tools for substance use disorders.</li> <li>» Develop a sub-registry of patients with high dose and/or chronic use of opioids and use panel management with a care team.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">CURES</a></li> <li>» <a href="#">Primary Care Clinic Redesign for Prescription Opioid Management – Common Registry Elements</a></li> <li>» See appendix for a resource list of assessment/screening tools and sources of patient materials.</li> </ul>
<b>Workforce</b>	<ul style="list-style-type: none"> <li>» Increase provider skills through tele-learning.</li> <li>» Encourage providers to use the Clinician Consultation Center warmline for real-time advice on SUD and MAT.</li> <li>» Initiate coaching (or "academic detailing") discussions with outlier prescribers (per data reports) by medical leadership or through peer review at least quarterly.</li> <li>» Engage care team members in doing tasks identified through the population registry, such as urine screening, risk assessments, CURES review, and referrals.</li> <li>» Expand care teams to include care coordinators, behavioral health specialists, pharmacists, and/or pain specialists.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">Clinician Consultation Center: Online and Telephone</a></li> <li>» <a href="#">Project ECHO Tele-Learning (NM and CA)</a></li> <li>» <a href="#">Opioid Stewardship and Chronic Pain: Guide for Primary Care Providers</a></li> <li>» <a href="#">Six Building Blocks: A Team-Based Approach to Improving Opioid Management in Primary Care</a></li> </ul>

# Strategy Two: Manage



Change Category	Change Ideas	Resources
<b>Clinical Practice</b>	<ul style="list-style-type: none"> <li>» Disseminate provider resources from health plans.</li> <li>» Adopt organizational standardized guidelines and policies for safe opioid prescribing and slow tapering to lower doses. (Tapering high doses to zero may worsen outcomes.) Standard guidelines should allow room for individualized taper plans based on what is right for individual patients.</li> <li>» Create time and space to listen to the patient about their individual pain journey. Work collaboratively with the patient to discuss medical risks, gain agreement that opioid risks outweigh benefits, tailor the taper plan to the individual, and closely monitor how patients tolerate the dose reduction so there is not significant decrease in function.</li> <li>» Utilize the four A's of pain monitoring for patients receiving opioids to assess and consistently document treatment outcomes and medical necessity of continuation. The 4A's are: Analgesia, Activities of Daily Living, Adverse Events, and Aberrant Drug-Related Behaviors.</li> <li>» Transition patients to buprenorphine for pain management.</li> <li>» Coprescribe naloxone for overdose prevention and to inform of overdose risks.</li> <li>» Avoid abrupt discontinuation of long-term opioids or benzodiazepines. While there is not clinical consensus on guidelines for managing benzodiazepine dependence in primary care, there are emerging guidelines on prescribing and taper management.</li> <li>» When using urine toxicology screening for changing management:               <ul style="list-style-type: none"> <li>+ Ensure the test has the needed accuracy and sensitivity for provider and patient confidence, and that providers have easily accessible interpretation guides.</li> <li>+ Consider in-house testing for point of care discussion and decision making.</li> <li>+ Use the testing and results as a dialogue tool for care management, and shared decision making rather than punishment.</li> <li>+ Never fire a patient based on the result of a urine test. Information is a data point. If a patient is to be discontinued from opioids, recognize this is a very high-risk transition; make sure there is a warm hand-off to ongoing MAT services.</li> </ul> </li> <li>» Communicate with specialists to develop care plans prior to surgery for patients with high doses.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">Kaiser Permanente Washington: Patients on Chronic Opioid Therapy for Chronic Non-Cancer Pain Safety Guideline</a></li> <li>» <a href="#">Safe Prescribing for Acute Pain Poster</a></li> <li>» <a href="#">Partnership Health Plan Provider Training Resources</a></li> <li>» <a href="#">Alameda County Prescriber Toolkit</a></li> <li>» <a href="#">Partnership HealthPlan: Tapering Toolkit and Video – The Art and Very Little Science of Tapering</a></li> <li>» <a href="#">Benzodiazepine and Z-Drug Safety Guideline: Tapering and Discontinuation</a></li> <li>» See appendix for a resource list of assessment/screening tools.</li> </ul>

# Strategy Two: Manage



Change Category	Change Ideas	Resources
<b>Leadership</b>	<ul style="list-style-type: none"> <li>» Take a systematic approach to implement clinical standards and best practices through clinical champion identification, development and dissemination of guidelines and best practices, performance data sharing and review to identify providers needing improvement, and individualized education.</li> <li>» Review pay-for-performance (P4P) measures of opioid safety for potential incentive-based revenue opportunities.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">Tackling the Opioid Crisis with Clear Prescription Guidelines, Accurate Monitoring, and Provider Education</a></li> <li>» <a href="#">IHA MY18 Value-Based P4P and Medicare Stars Measure Set</a></li> </ul>
<b>Access to Care</b>	<ul style="list-style-type: none"> <li>» Offer group visits, facilitated by a behavioral health specialist with participation by the primary care provider, for patients with chronic pain and taking opioids.</li> </ul>	
<b>Patient Engagement</b>	<ul style="list-style-type: none"> <li>» Share patient materials about safe prescribing, treatment considerations, and tapering.</li> <li>» Engage patients in a dialogue about treatment and goals by using a patient-centered tool, also known as informed consent and agreements, but do not use it as a punitive contract to deny opioid treatment or dismiss from care.</li> <li>» Include chronic pain patients at higher risk (high dose, combination with sedatives) in care management or behavioral health programs to help manage anxiety and needs if tapers are indicated.</li> <li>» Ensure social and psychological supports are in place to manage the psychological "pain of life" issues that may resurface when opioids are reduced.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">Controlled Substance and Wellness Agreement (CSWA)</a></li> <li>» <a href="#">Tapering Booklet</a></li> </ul>
<b>Community Support and Engagement</b>	<ul style="list-style-type: none"> <li>» Distribute public service announcements for audiences in movie theaters, buses, radio shows, etc.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">California Opioid Safety Network of Coalitions</a></li> <li>» <a href="#">Outpatient Radio</a></li> </ul>



## INNOVATIVE IDEAS

### Addressing the psychology and physiology of pain

Cedars-Sinai Medical Care Foundation has implemented a chronic pain program — a multidisciplinary and multimodal approach to the ambulatory management of patients with chronic pain, including those with chronic opioid usage. After extensive literature review and discussion with experts who demonstrate “best practices,” Cedars-Sinai developed an approach to leverage a multidisciplinary team to support primary care physicians in their management of these patients. Patients with chronic pain can access the services of the team led by a Medical Director working closely with primary care physicians. Patients on high dose opioids or with severe needs are cared for directly by the program’s Medical Director, a pain specialist experienced in both acute and chronic pain management, interventional therapies, pharmacotherapy, and opioid tapering. Other patients remain under the care of the primary care physician and receive additional support through a pharmacist-supported opioid tapering clinic as well as individual and group cognitive behavioral therapy led by a pain psychologist.

Foundational to their efforts has been the recognition of the role of pain psychology — behavioral elements of pain perception — that can be powerful in engaging patients in more effective partnership. These programs interface with a network of contracted physical therapists to develop and tailor a package of services to meet different patient needs. Looking forward, the program is scaling up with the addition of clinicians and mental health specialists aligned with the vision and experienced in navigating restrictive patient coverage for adjunctive mental health services.

Patients on high dose opioids or with severe needs are cared for directly by the program’s Medical Director, a pain specialist experienced in both acute and chronic pain management, interventional therapies, pharmacotherapy, and opioid tapering.



# Strategy Two: Manage



## Tapering Caution

From Andrew Herring, MD

Every day, I see patients in the ED who have been ‘fired from pain management’ – sometimes because they have opioid use disorder and sometimes they are pain patients who made a legitimate mistake, such as not realizing they were not supposed to fill their dentist’s prescription after oral surgery per the form they signed over a year ago. Or they are put on fast tapers they cannot tolerate. Pain patients and OUD patients are not that different – the brain does not differentiate the reason for long-term opioid use and the craving, severe withdrawal symptoms, and desperation look the same. Being cut off from opioids after years of dependence is an incredibly high-risk moment; I am seeing patients go into crisis, even suicidal thoughts, and do things out of desperation like turning to street drugs.

We know that people increase their risk by going from low-dose to high-dose opioids. But we do not have enough data to know if we are decreasing risks in large population by involuntary tapers to arbitrary doses. A large meta-analysis showed the data on tapering is poor quality and not conclusive. [Data from the Veterans Administration](#) (VA) is raising concerns that rapid tapers may increase suicide ideation and mental health crises.

Now is a time for caution. We should only be tapering if we are making people better. Until we have data to know that tapering leads to better outcomes and lower death rates, we should focus on dose stabilization and co-prescribing naloxone – and not involuntary tapers that cause patients to decompensate.

## Tapering Guidance

From Andrea Rubinstein, MD

Safe opioid prescribing takes time. It works best when the patient is an active partner in the process and the tapering plan is customized. This is about making the patient better. Sometimes that means lowering their dose, but we have to look at the entire patient – and what will improve their health – and not just their opioid dose.

- » Risks of opioids far transcend the overdose risk. Endocrine risk, bone density loss, depression, cardiac risk, and sleep apnea are all consequences of opioid use and basing a taper on these findings is far better than tapering simply based on dose. Providers need to taper patients to make them better, not to simply make the dose lower. Tapering a patient too fast or to zero can drive them to illicit drug use.
- » Patients need to understand that we are tapering them to make them better. When tapers are discussed in terms of medical risks as mentioned above, they will usually “buy in.” If we taper them against their will, they will usually sabotage the process by going to another doctor or obtaining medication from non-prescribed sources. Both of these have the potential to increase risk for our patients, and this is the opposite of what we want. Gaining at least agreement – if not consensus – that risks outweigh benefits is key, but so is reassuring the patient that we will help them, be there for them, and support them in the process of the taper.
- » Patients need close follow-up while tapering to make sure they tolerate the dose reduction without significant decrease in function, such as missed work or family obligations. Some patients tolerate 10% dose reductions. Some do not. We need to work with each patient’s physiology when tapering them.
- » Use common sense and adjust along the way. Stressful life events or mental health issues may slow a scheduled taper. For instance, avoid tapering during December holidays.

For more guidance, listen to Dr. Rubinstein’s talk: [Tapering Toolkit and Video – The Art and Very Little Science of Tapering](#)



STRATEGY **THREE**

# TREAT

## What are we trying to accomplish?

Expand and streamline access to MAT in health care settings.

## How will we know a change is an improvement?

Impact	Measure
Increase access to appropriate treatment	<ul style="list-style-type: none"> <li>✔ Percent of patients with alcohol or opioid use disorder who receive MAT</li> </ul>
Increase use of buprenorphine for addiction and pain treatment	<ul style="list-style-type: none"> <li>✔ Number of buprenorphine prescriptions per 1,000 patients</li> <li>✔ Percent of patients with buprenorphine prescriptions who had opioid prescriptions in the prior 90 days</li> </ul>
Increase provider adoption of MAT	<ul style="list-style-type: none"> <li>✔ Number or percent of x-waivered prescribers</li> <li>✔ Number or percent of new x-waivered prescribers writing buprenorphine prescriptions</li> </ul>
Increase MAT program enrollment, engagement, retention	<ul style="list-style-type: none"> <li>✔ Percent of patients with opioid use disorder enrolled in MAT program</li> <li>✔ Average length of stay in treatment</li> <li>✔ Appointment show rate</li> </ul>
Improve patient quality of life	<ul style="list-style-type: none"> <li>✔ Percent of patients with OUD in treatment whose score on Quality of Life Survey increased from previous score</li> </ul>



### Consideration: train all providers or some?

Some organizations require all clinicians to obtain an x-waiver to meet the community demand and increase access to MAT. Other organizations support a few motivated clinicians who are passionate about the work and skilled in harm reduction approaches. Consider which approach makes sense for your organization’s patient population, workflows, and resources.

# Strategy Three: Treat



What changes can we make that will result in improvement?		
Change Category	Change Ideas	Resources
<b>Data / Transparency</b>	<ul style="list-style-type: none"> <li>» Review county-level data for buprenorphine prescriptions, ED visits, hospital visits, and treatment gaps.</li> <li>» Monitor and share data on the number of patients diagnosed, receiving treatment, and those at high risk of overdose.</li> <li>» Identify possible patients through ED utilization and diagnosis lists and/or at-risk and high-risk patient lists from health plans or EHR or registry queries.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">California Opioid Overdose Surveillance Dashboard</a></li> <li>» <a href="#">California County Fact Sheets: Treatment Gaps in Opioid-Agonist Medication Assisted Therapy (OA-MAT)</a></li> <li>» <a href="#">Overcoming Data-Sharing Challenges in the Opioid Epidemic: Integrating Substance Use Disorder Treatment in Primary Care</a></li> </ul>
<b>Health Information Technology</b>	<ul style="list-style-type: none"> <li>» Create EHR alerts for:                             <ul style="list-style-type: none"> <li>+ History of overdose</li> <li>+ Overdose risk</li> <li>+ Prescription of naloxone</li> <li>+ Treatment when related ICD-10 codes are used</li> </ul> </li> <li>» Create EHR visit templates for SUD treatment.</li> <li>» Create EHR care management plans specific to SUD treatment.</li> <li>» Integrate assessment tools for opioid withdrawal.</li> <li>» Create a sub-registry of patients with OUD and incorporate monitoring of MAT.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">Clinical Opioid Withdrawal Scale (COWS)</a></li> <li>» See appendix for a resource list of assessment/screening tools and sources of patient materials.</li> </ul>
<b>Workforce</b>	<ul style="list-style-type: none"> <li>» Train all prescribers in MAT or select a passionate subgroup to treat all patients in the practice.</li> <li>» Support newly x-waivered providers with experienced mentors to answer questions, shadow visits, and do case conferences or peer learning.</li> <li>» Train staff and providers on harm reduction, trauma-informed care, opioid use disorder, and the case for MAT.</li> <li>» For a more robust approach, create a multidisciplinary MAT care team that includes a clinician, a case manager (navigator or nurse), and a behavioral health specialist (e.g. certified drug and alcohol counselor, or licensed clinical social worker). Proactively mitigate case manager burnout, as they are doing most of the direct patient contact.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">Substance Use Consultation: Online and Telephone</a></li> <li>» <a href="#">Project Echo Tele-Learning</a></li> <li>» <a href="#">The National Center for Complex Health and Social Needs – Online Courses</a></li> <li>» <a href="#">Partnership Health Plan Provider Training Resources</a></li> </ul>

# Strategy Three: Treat

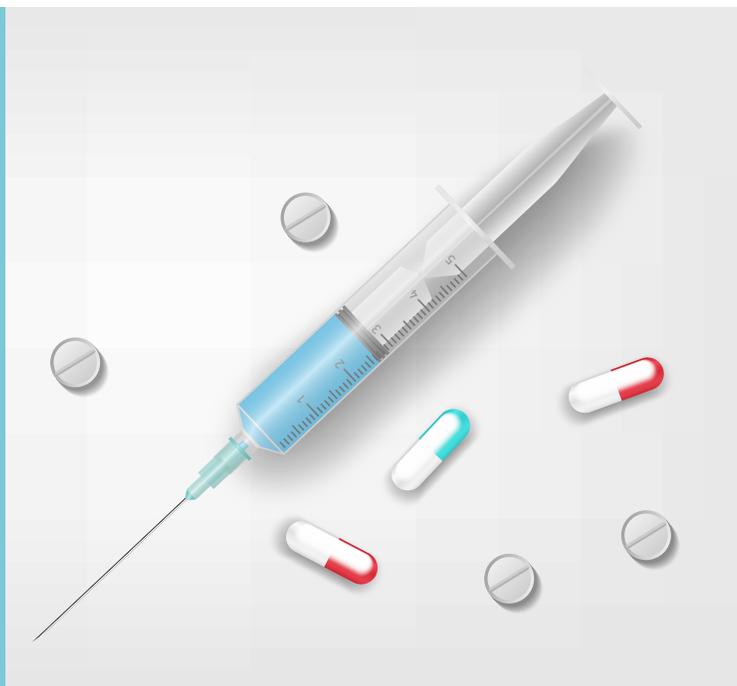


Change Category	Change Ideas	Resources
<b>Clinical Practice</b>	<ul style="list-style-type: none"> <li>» Adopt organizational standardized MAT guidelines and policies.</li> <li>» Build intake workflows to optimize timely access for new patients while allowing assessment of needed level of care (with referral workflows for patients needing higher levels of care).</li> <li>» Define tiers of care for patients to allow step-up and step-down of service intensity.</li> <li>» Consider low-threshold (quick-start) protocols while patients await full assessment (equivalent to starting antipsychotics with severe mental illness before enrolling in behavioral health).</li> <li>» Provide behavioral health specialists with flexible schedules (open appointments), allowing urgent appointments, covisits with primary care providers (PCPs), and warm hand-offs with PCPs or MAT providers.</li> <li>» Coprescribe naloxone.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">Integrating Buprenorphine Treatment for Opioid Use Disorder in Primary Care</a></li> <li>» <a href="#">MATx Mobile App</a></li> <li>» <a href="#">ASAM Continuum tool</a></li> <li>» <a href="#">ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use</a></li> </ul>
<b>Leadership</b>	<ul style="list-style-type: none"> <li>» Identify a clinical primary care champion.</li> <li>» Create an implementation team to create policies, procedures, workflows, training, care coordination, staffing needs, and planning for scale and expansion.</li> <li>» Build partnerships with:               <ul style="list-style-type: none"> <li>+ Hospitals, specifically those using MAT in the ED and inpatient settings</li> <li>+ Outpatient treatment facilities</li> <li>+ Residential treatment facilities</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">ED-Bridge Program</a></li> <li>» <a href="#">Project SHOUT (MAT in hospitals)</a></li> <li>» <a href="#">Treating Addiction in the Primary Care Safety Net: Implementing Medication-Assisted Treatment and the Lessons Learned</a></li> </ul>
<b>Access to Care</b>	<ul style="list-style-type: none"> <li>» Create rapid primary care access for patients initiating MAT, especially for patients referred from hospitals or jails ("bridge clinics" offer walk-in hours and MAT quick-starts, or allow drop-in appointment flexibility).</li> <li>» Offer group visits, facilitated by a behavioral health specialist in parallel with one-on-one MAT clinician appointments before/ after group.</li> <li>» Offer home inductions of buprenorphine with patient instruction sheets.</li> <li>» Consider partnerships with telehealth providers.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">Home-based Induction</a></li> <li>» <a href="#">Telehealth Technologies in the Provision of MAT in the Medi-Cal Program</a></li> <li>» <a href="#">CSAM buprenorphine toolkit with home induction worksheets</a></li> </ul>

# Strategy Three: Treat



Change Category	Change Ideas	Resources
<b>Patient Engagement</b>	<ul style="list-style-type: none"><li>» Share patient materials about treatment options.</li><li>» Promote a harm-reduction model: naloxone prescribing and dispensing and partnerships with local harm reduction organizations (needle exchanges).</li><li>» Be extremely flexible for new patients: drop-in options, waiving late fees, and not turning away patients who are late or do not bring insurance cards.</li></ul>	<ul style="list-style-type: none"><li>» <a href="#">Treatment Options: Pros and Cons</a></li><li>» <a href="#">Buprenorphine-Naloxone: What You Need to Know</a></li><li>» <a href="#">ASAM Opioid Addiction Treatment: A Guide for Patients, Families, and Friends</a></li></ul>
<b>Community Support and Engagement</b>	<ul style="list-style-type: none"><li>» Participate in local opioid safety coalitions (public health medical societies, hospitals, clinics, law enforcement, judicial system, treatment centers, and advocates).</li><li>» Coordinate referrals and care with external treatment centers (outpatient and residential) and behavioral therapy.</li></ul>	<ul style="list-style-type: none"><li>» <a href="#">California Opioid Safety Network of Coalitions</a></li></ul>



# Strategy Three: Treat



## INNOVATIVE IDEAS

### Peer mentoring

Although Santa Rosa Community Health in Sonoma County requires all physicians who care for adults to be x-waivered, they recognize that the waiver alone is not enough. Newly x-waivered providers are initially trained on organizational safe-prescribing guidelines and protocol and are then paired with an experienced x-waivered provider, an internal program known as elbow-to-elbow training. This co-management model reinforces safe-prescribing practices, highlights patient interactions, and allows for collaboration regarding tapering and treatment.

### Team-based MAT programs

While not all practices have the resources to support integrated care teams (and MAT can be effective without them), many practices find care teams a critical component of their MAT programs.

### High-Touch Case Management

Case managers coordinate and support care for MAT patients, communicating with patients frequently regarding treatment progress and overall well-being. Case managers can join patients during provider visits or check in with them before or after.

### Embedded Behavioral Health Care

On-site behavioral specialists, embedded in both primary care and MAT programs, have flexible schedules, giving providers greater accessibility to call upon them for immediate needs.

### Patient-Centered Processes

Centering care around the patient is critical to engaging and retaining patients: training staff in trauma-informed care and de-escalation skills; providing warm welcomes (instead of punitive or paternalistic language) when faced with disruptive behavior; allowing drop-in visits or flexible appointment times, especially early in treatment; scheduling provider appointments before or after group sessions, instead of during the group, so patients participate in the entire session; and offering drop-in appointments and same-day or home inductions.





STRATEGY **FOUR**

# STOP DEATHS

## What are we trying to accomplish?

Promote harm reduction, including streamlining access to naloxone for overdose reversal.

## How will we know a change is an improvement?

### Impact

Stop Overdose Deaths

### Measure

- ✔ Percent of patients with documented opioid use or prescription prescribed naloxone
- ✔ Percent of patients who used prescribed naloxone
- ✔ Opioid overdose death rate

## INNOVATIVE IDEAS

### Predicting Overdose Risk

Kaiser Permanente in Southern California analyzed population data to identify overdose risk factors and create EHR alerts.

While prediction models are in development, they only predict overdose risk two-thirds of the time. Because providers (and models) are not precise in predicting overdose risk, the San Francisco Department of Public Health recommends that all patients receiving daily long-term opioids receive a prescription of naloxone; doing this cut opioid-related ED visits by 63%.



# Strategy Four: Stop Deaths



What change can we make that will result in improvement?		
Change Category	Change Ideas	Resources
<b>Data / Transparency</b>	<ul style="list-style-type: none"> <li>» Review county level data for overdose deaths.</li> <li>» Share data on overdose ED visits and deaths, naloxone prescriptions for patients with &gt;50 MME, and naloxone prescription fill rates.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">California Opioid Overdose Surveillance Dashboard</a></li> </ul>
<b>Health Information Technology</b>	<ul style="list-style-type: none"> <li>» Create EHR alerts for:                             <ul style="list-style-type: none"> <li>+ History of overdose</li> <li>+ Overdose risk</li> <li>+ Prescription of naloxone</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">Prescribing Naloxone: Instructions for healthcare providers with patient inclusion criteria and billing options</a></li> </ul>
<b>Clinical Practice</b>	<ul style="list-style-type: none"> <li>» Adopt organizational standardized guidelines and policies for prescribing naloxone.</li> <li>» Engage pharmacists to dispense and furnish naloxone.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">Naloxone for Opioid Safety: A provider's guide</a></li> <li>» <a href="#">Statewide Standing Order for Naloxone</a></li> </ul>
<b>Leadership</b>	<ul style="list-style-type: none"> <li>» Send personal letters notifying clinicians of an opioid-related overdose death in their practice and reiterating guidelines for safe prescribing.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">Opioid prescribing decreases after learning of a patient's fatal overdose</a></li> </ul>
<b>Patient Engagement</b>	<ul style="list-style-type: none"> <li>» Share patient materials about overdose risk and naloxone.</li> <li>» Encourage pharmacists to teach patients about naloxone.</li> </ul>	<ul style="list-style-type: none"> <li>» <a href="#">Opioid safety and how to use naloxone: A guide for patients and caregivers</a></li> </ul>

# Case Study

## Sustaining complex, team-based MAT care

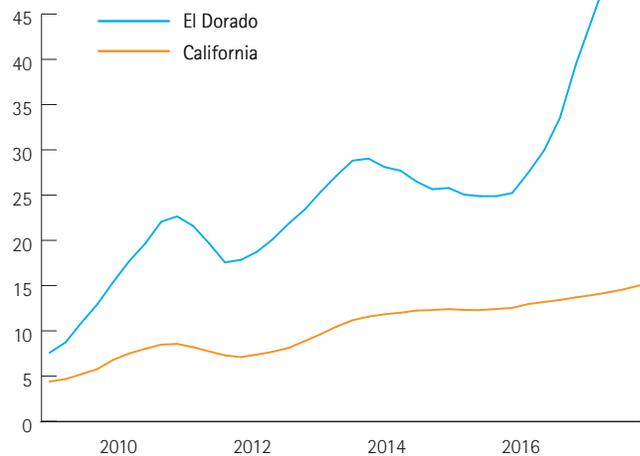
### El Dorado Community Health Centers, El Dorado county

After working to address safe prescribing in their health centers, El Dorado Community Health Centers (EDCHC), a federally qualified health center in El Dorado County, focused on integrating addiction treatment. EDCHC created its team-based MAT program in January 2016 with California Health Care Foundation and Health Resources and Services Administration (HRSA) grant funding, including physical and mental health support with case management and substance use counseling. Empowered provider champions lead by example: sharing patient stories in provider meetings, offering clinical rotations and shadowing, and reviewing individual patient cases with PCPs and technical consultants via webinar-based training. By December 2017, the program had served 195 patients.

Buprenorphine inductions are offered in the clinic, at home, and the local ED. Refills are offered through attendance in a group visit that includes psychoeducation, relapse prevention, and an individual medical visit with the prescriber. Individual behavioral health treatment is not required but is offered case-by-case after behavioral health assessment during intake. Those patients starting buprenorphine in the ED are offered rapid follow-up in the MAT clinic.

EDCHC encountered challenges in serving high-risk populations, such as adolescents, pregnant women, and patients released from incarceration, as well as patients with private insurance (due to health plan authorization policies). To overcome these challenges, the program is working to expand MAT access in the broader provider community, offering site visits and allowing community providers to shadow the EDCHC MAT clinicians. EDCHC partners with the local hospital to offer rapid follow-up in the health center's MAT clinic after buprenorphine starts in the ED, and collaborates with county substance use administrators, probation, superior court, and county jail to expand MAT access to high-risk groups. Recent collaboration with Aegis, through the California Hub and

### Buprenorphine Prescriptions by Patient Location: Age-Adjusted Rate per 1,000 Residents



Source: California Department of Justice - Controlled Substance Utilization Review and Evaluation System Data

### MAT Program Goals

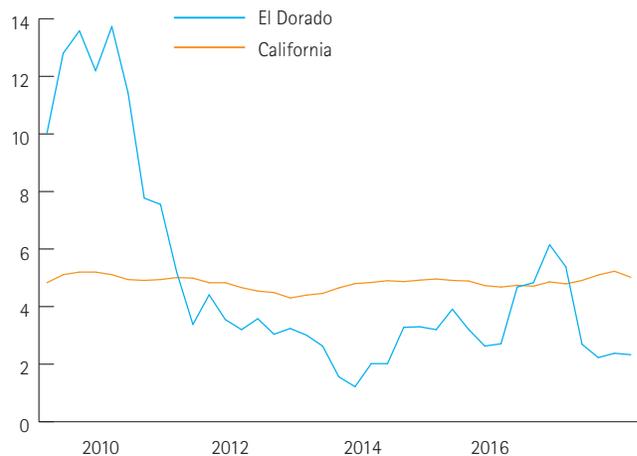
- ✔ Decrease overdose deaths in El Dorado County.
- ✔ Increase access to MAT in the clinic.
- ✔ Integrate MAT into primary care settings for whole person care with compassion, respect, and reduced stigma.
- ✔ Reduce opioid-related ED and hospital utilization.
- ✔ Develop new payment models that sustain complex, team-based MAT.
- ✔ Expand the community's MAT capacity.

# Case Study

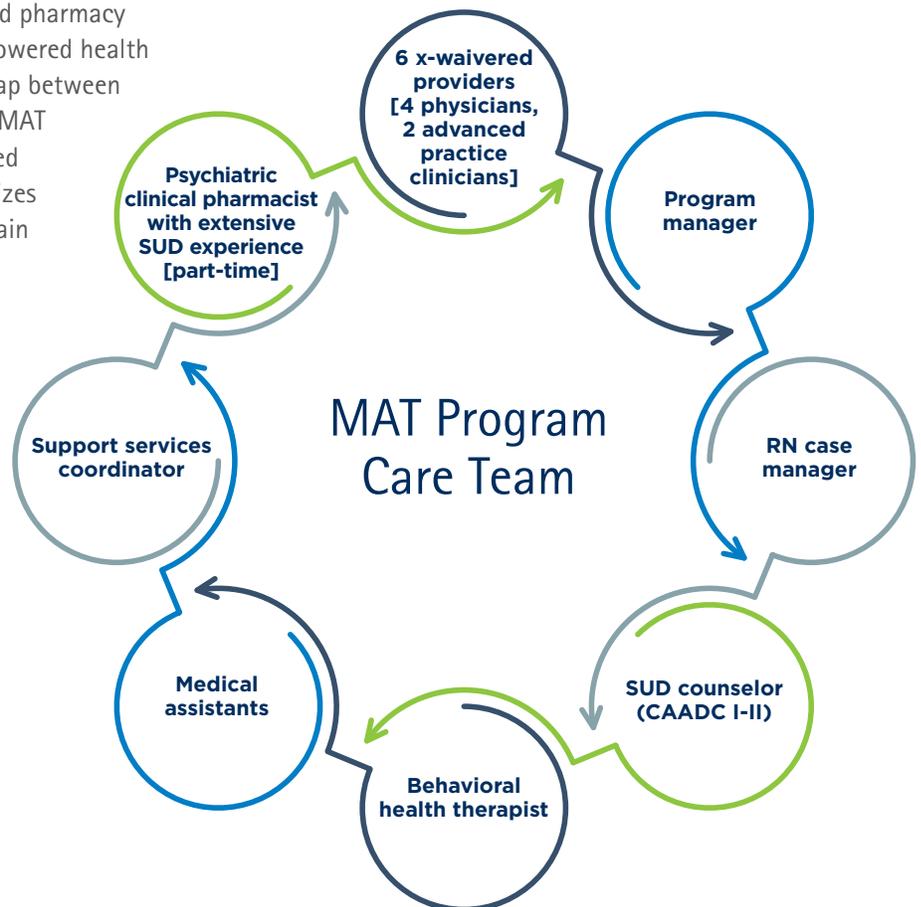
Spoke model, provides additional funding for program participants who are “unfunded or underfunded” with health insurance. Due to requirements as a Federally Qualified Health Center as well as Medi-Cal requirements, EDCHC focuses on PCP enrollment of patients for continuity of patients in the MAT program. The health center is also exploring serving as a temporary referral destination for primary care providers in their community as well as supporting the establishment of other MAT services within the area.

Sustaining the team-based MAT program beyond grant funding was integrated into EDCHC’s planning from the outset. Tracking data on costs and outcomes was key to keeping the program on track and advocating for new reimbursement. Working with its local Medi-Cal health plan, the team analyzed data of pre- and post-MAT program health care costs, including ED and hospital admissions, outpatient specialty care, and pharmacy claims, showing that the MAT program lowered health plan costs. EDCHC then calculated the gap between reimbursement and the costs to run the MAT program. They are now proposing a shared savings model in which the payer subsidizes the health center’s MAT program to sustain the cost savings it generates for the payer. EDCHC is hoping its experience and methodology can be used by other health care delivery organizations to partner with payers to increase MAT access for patients.

**All Opioid Overdose Deaths: Age-Adjusted Rate per 100,000 Residents**



Source: CDPH Vital Statistics Multiple Cause of Death Files



# On the Horizon

Vanguard organizations are continuing to move forward with their opioid safety efforts; interviewees shared where they are headed and their hopes for future improvements in California.

## Data/Transparency

- ✔ Providers and plans need to collaborate on data analysis to measure outcomes and costs.

## Health Information Technology

- ✔ Organizations need help from EHR vendors improve opioid safety: risk stratification reports and clinical alerts, listing opioids, and controlled substances with depressants in the pharmacy drug list, checkboxes for reviewing CURES, and patient-friendly care management plans.

## Workforce Development

- ✔ Organizations need MAT training opportunities across the spectrum: beginner to advanced.

## Clinical Practice

- ✔ Patients need easier access to cognitive behavioral therapy for acute and chronic pain, and providers need training in setting appropriate expectations of pain relief and addressing patient fears and readiness for opioid reduction, when needed.

## Leadership And Sustainability

- ✔ Organizations need sustainable ways to fund MAT: alternative payment models with health plans or pay-for-performance incentives, HRSA funding, group visits, Drug Medi-Cal, federal MAT funding opportunities.

## Access To Care

- ✔ Telemedicine is in greater demand, especially in rural areas: individual and group therapy and medication management by prescribers can be done on mobile phones or laptops.
- ✔ The MAT Expansion Program is creating new access points in EDs, hospitals, primary care, mental health facilities, jails, residential treatment centers, and other locations; primary care providers can set up referral relationships to facilitate ongoing treatment after new MAT starts in other settings.

## Patient Engagement

- ✔ Organizations are working to support patient-centered care in pain management, MAT, and overdose prevention with naloxone.
- ✔ Reports are increasing about "opioid crackdown" approaches leading to bad outcomes, including suicide and street drug use. Fast tapers from high doses and mandatory tapers to zero are likely to cause more harm than benefit.

## Community Support And Engagement

- ✔ Organizations are shifting attention to prevention and addressing the stigma of addiction in the community, including engaging youth and partnering with law enforcement.

# Appendix

## Table of Contents

### Change Ideas by Change Category

Data / Transparency	27
Health Information Technology	27
Workforce Development	28
Clinical Practice	29
Leadership & Sustainability	30
Access To Care	30
Patient Engagement	31
Community Support & Engagement	31

### Measures Identified by Key Informant Organizations

Prevent	32
Manage	32
Treat	33
Stop	33

### Resource List

Data / Transparency	34
Health Information Technology	34
Workforce Development	34
Clinical Practice	34
Leadership & Sustainability	35
Access to Care	35
Patient Engagement	36
Community Support & Engagement	36

<b>Abbreviations</b>	37
----------------------	----

<b>References</b>	38
-------------------	----

# Appendix

## Change Ideas by Change Category

Data / Transparency	
<b>Prevent</b>	<ul style="list-style-type: none"><li>» Review county-level data for prescription rates and opioid-naïve residents with long-acting opioid prescriptions.</li><li>» Monitor and share data on prescribing rates and utilization of alternative therapies.</li></ul>
<b>Manage</b>	<ul style="list-style-type: none"><li>» Review county-level data for MME levels, multiple medications, and multiple prescribers.</li><li>» Extract EHR data to provide monthly provider feedback on performance, adherence to prescribing guidelines, and lists of patients at risk, including high doses and/or multiple medications, such as benzodiazepine or carisoprodol.</li><li>» Monitor and share data on adoption of prescribing guidelines and substance use disorder screening for peer benchmarking. Adjust for panel sizes or exclude specific specialties as applicable.</li></ul>
<b>Treat</b>	<ul style="list-style-type: none"><li>» Review county-level data for buprenorphine prescriptions, ED visits, hospital visits, and treatment gaps.</li><li>» Monitor and share data on the number of patients diagnosed, receiving treatment, and those at high risk of overdose.</li><li>» Identify possible patients through ED utilization and diagnosis lists and/or at-risk and high-risk patient lists from health plans or EHR or registry queries.</li></ul>
<b>Stop</b>	<ul style="list-style-type: none"><li>» Review county level data for overdose deaths.</li><li>» Share data on overdose ED visits and deaths, naloxone prescriptions for patients with &gt;50 MME, and naloxone prescription fill rates.</li></ul>

Health Information Technology	
<b>Prevent</b>	<ul style="list-style-type: none"><li>» Create electronic health record (EHR) visit template for pain management.</li><li>» Integrate pain assessment tools.</li><li>» Add patient materials for pain management and therapies.</li><li>» Develop a registry of patients managing chronic pain.</li><li>» Selectively build in decision support to guide safer prescribing.</li></ul>
<b>Manage</b>	<ul style="list-style-type: none"><li>» Create EHR alerts for:<ul style="list-style-type: none"><li>» Prescribing outside of clinical guidelines</li><li>» High doses for new starts</li><li>» Concurrent prescription of benzodiazepines and opioids</li></ul></li><li>» Checking the Controlled Substance Utilization, Review and Evaluation Systems (CURES) every four months, and for initial prescriptions</li><li>» Create EHR visit templates for taper plans and pain monitoring with treatment outcomes.</li><li>» Add patient educational materials about opioids and appropriate use.</li><li>» Deactivate specific unsafe medications in the EHR formulary, including carisoprodol and oxymorphone ER.</li><li>» Integrate screening tools for substance use disorders.</li><li>» Develop a sub-registry of patients with high dose and/or chronic use of opioids and use panel management with a care team.</li></ul>

# Appendix

## Change Ideas by Change Category *(continued)*

### Health Information Technology

- Treat**
- » Create EHR alerts for:
    - » History of overdose
    - » Overdose risk
    - » Prescription of naloxone
  - » Treatment when related ICD-10 codes are used
  - » Create EHR visit templates for SUD treatment.
  - » Create EHR care management plans specific to SUD treatment.
  - » Integrate assessment tools for opioid withdrawal.
  - » Create a sub-registry of patients with OUD and incorporate monitoring of MAT.

- Stop**
- » Create EHR alerts for:
    - » History of overdose
    - » Overdose risk
    - » Prescription of naloxone

### Workforce Development

- Prevent**
- » Disseminate education and training resources to providers for appropriate opioid prescribing and non-opioid pain treatments.

- Manage**
- » Increase provider skills through tele-learning.
  - » Encourage providers to use the Clinician Consultation Center warmline for real-time advice on SUD and MAT.
  - » Initiate coaching (or "academic detailing") discussions with outlier prescribers (per data reports) by medical leadership or through peer review at least quarterly.
  - » Engage care team members in doing tasks identified through the population registry, such as urine screening, risk assessments, CURES review, and referrals.
  - » Expand care teams to include care coordinators, behavioral health specialists, pharmacists, and/or pain specialists.

- Treat**
- » Train all prescribers in MAT or select a passionate subgroup to treat all patients in the practice.
  - » Support newly x-waivered providers with experienced mentors to answer questions, shadow visits, and do case conferences or peer learning.
  - » Train staff and providers on harm reduction, trauma-informed care, opioid use disorder, and the case for MAT.
  - » For a more robust approach, create a multidisciplinary MAT care team that includes a clinician, a case manager (navigator or nurse), and a behavioral health specialist (e.g. certified drug and alcohol counselor, or licensed clinical social worker). Proactively mitigate case manager burnout, as they are doing most of the direct patient contact.

# Appendix

## Change Ideas by Change Category *(continued)*

Clinical Practice	
<b>Prevent</b>	<ul style="list-style-type: none"><li>» Adopt organization-wide standardized guidelines and workflows for pain management and appropriate opioid prescribing, including for specific populations and settings (adolescents, pregnant women, urgent care, and specialties).</li></ul>
<b>Manage</b>	<ul style="list-style-type: none"><li>» Disseminate provider resources from health plans.</li><li>» Adopt organizational standardized guidelines and policies for safe opioid prescribing and slow tapering to lower doses. (Tapering high doses to zero may worsen outcomes.) Standard guidelines should allow room for individualized taper plans based on what is right for individual patients.</li><li>» Create time and space to listen to the patient about their individual pain journey. Work collaboratively with the patient to discuss medical risks, gain agreement that opioid risks outweigh benefits, tailor the taper plan to the individual, and closely monitor how patients tolerate the dose reduction so there is not significant decrease in function.</li><li>» Utilize the four A's of pain monitoring for patients receiving opioids to assess and consistently document treatment outcomes and medical necessity of continuation. The 4A's are: Analgesia, Activities of Daily Living, Adverse Events, and Aberrant Drug-Related Behaviors.</li><li>» Transition patients to buprenorphine for pain management.</li><li>» Coprescribe naloxone for overdose prevention and to inform of overdose risks.</li><li>» Avoid abrupt discontinuation of long-term opioids or benzodiazepines. While there is not clinical consensus on guidelines for managing benzodiazepine dependence in primary care, there are emerging guidelines on prescribing and taper management.</li><li>» When using urine toxicology screening for changing management:<ul style="list-style-type: none"><li>» Ensure the test has the needed accuracy and sensitivity for provider and patient confidence, and that providers have easily accessible interpretation guides.</li><li>» Consider in-house testing for point of care discussion and decision making.</li><li>» Use the testing and results as a dialogue tool for care management, and shared decision making rather than punishment.</li><li>» Never fire a patient based on the result of a urine test. Information is a data point. If a patient is to be discontinued from opioids, recognize this is a very high-risk transition; make sure there is a warm hand-off to ongoing MAT services.</li></ul></li><li>» Communicate with specialists to develop care plans prior to surgery for patients with high doses.</li></ul>
<b>Treat</b>	<ul style="list-style-type: none"><li>» Adopt organizational standardized MAT guidelines and policies.</li><li>» Build intake workflows to optimize timely access for new patients while allowing assessment of needed level of care (with referral workflows for patients needing higher levels of care).</li><li>» Define tiers of care for patients to allow step-up and step-down of service intensity.</li><li>» Consider low-threshold (quick-start) protocols while patients await full assessment (equivalent to starting antipsychotics with severe mental illness before enrolling in behavioral health).</li><li>» Provide behavioral health specialists with flexible schedules (open appointments), allowing urgent appointments, co-visits with primary care providers (PCPs), and warm hand-offs with PCPs or MAT providers.</li><li>» Coprescribe naloxone.</li></ul>
<b>Stop</b>	<ul style="list-style-type: none"><li>» Adopt organizational standardized guidelines and policies for prescribing naloxone.</li><li>» Engage pharmacists to dispense and furnish naloxone.</li></ul>

# Appendix

## Change Ideas by Change Category *(continued)*

Leadership & Sustainability	
<b>Prevent</b>	<ul style="list-style-type: none"><li>» Identify clinical champions to lead work in opioid safety.</li><li>» Convene a steering committee of multiple disciplines and functions, including behavioral health.</li><li>» Develop an incremental opioid safety plan, working with staff and providers to get buy-in.</li><li>» Create a business case: ensure changes are financially sustainable, look for funding opportunities for start-up costs, and identify reimbursement strategies for long-term.</li><li>» Participate in health plan committees related to opioid safety (e.g. pharmacy and therapeutics, quality improvement): give feedback, influence policies, and bring back information to your organization.</li></ul>
<b>Manage</b>	<ul style="list-style-type: none"><li>» Take a systematic approach to implement clinical standards and best practices through clinical champion identification, development and dissemination of guidelines and best practices, performance data sharing and review to identify providers needing improvement, and individualized education.</li><li>» Review pay-for-performance (P4P) measures of opioid safety for potential incentive-based revenue opportunities.</li></ul>
<b>Treat</b>	<ul style="list-style-type: none"><li>» Identify a clinical primary care champion.</li><li>» Create an implementation team to create policies, procedures, workflows, training, care coordination, staffing needs, and planning for scale and expansion.</li><li>» Build partnerships with:<ul style="list-style-type: none"><li>» Hospitals, specifically those using MAT in the ED and inpatient settings</li><li>» Outpatient treatment facilities</li><li>» Residential treatment facilities</li></ul></li></ul>
<b>Stop</b>	<ul style="list-style-type: none"><li>» Send personal letters notifying clinicians of an opioid-related overdose death in their practice and reiterating guidelines for safe prescribing.</li></ul>
Access To Care	
<b>Prevent</b>	<ul style="list-style-type: none"><li>» Identify access points for alternative pain management.</li><li>» Offer group medical visits for chronic pain management.</li><li>» Work with health plan, local coalition, and community to identify behavioral health specialists, evidence-based pain specialists, and SUD treatment resources.</li><li>» Develop chronic pain management service packages, integrating evidence-based alternative pain management therapies.</li></ul>
<b>Manage</b>	<ul style="list-style-type: none"><li>» Offer group visits, facilitated by a behavioral health specialist with participation by the primary care provider, for patients with chronic pain and taking opioids.</li></ul>
<b>Treat</b>	<ul style="list-style-type: none"><li>» Create rapid primary care access for patients initiating MAT, especially for patients referred from hospitals or jails ("bridge clinics" offer walk-in hours and MAT quick-starts, or allow drop-in appointment flexibility).</li><li>» Offer group visits, facilitated by a behavioral health specialist in parallel with one-on-one MAT clinician appointments before/ after group.</li><li>» Offer home inductions of buprenorphine with patient instruction sheets.</li><li>» Consider partnerships with telehealth providers.</li></ul>

# Appendix

## Change Ideas by Change Category *(continued)*

Patient Engagement	
<b>Prevent</b>	<ul style="list-style-type: none"><li>» Build workflows to allow easy access to patient materials about pain management and alternative therapies.</li><li>» Distribute patient-centered materials to support patients in managing chronic pain.</li></ul>
<b>Manage</b>	<ul style="list-style-type: none"><li>» Share patient materials about safe prescribing, treatment considerations, and tapering.</li><li>» Engage patients in a dialogue about treatment and goals by using a patient-centered tool, also known as informed consent and agreements, but do not use it as a punitive contract to deny opioid treatment or dismiss from care.</li><li>» Include chronic pain patients at higher risk (high dose, combination with sedatives) in care management or behavioral health programs to help manage anxiety and needs if tapers are indicated.</li><li>» Ensure social and psychological supports are in place to manage the psychological “pain of life” issues that may resurface when opioids are reduced.</li></ul>
<b>Treat</b>	<ul style="list-style-type: none"><li>» Share patient materials about treatment options.</li><li>» Promote a harm-reduction model: naloxone prescribing and dispensing and partnerships with local harm reduction organizations (needle exchanges).</li><li>» Be extremely flexible for new patients: drop-in options, waiving late fees, and not turning away patients who are late or do not bring insurance cards.</li></ul>
<b>Stop</b>	<ul style="list-style-type: none"><li>» Share patient materials about overdose risk and naloxone.</li><li>» Encourage pharmacists to teach patients about naloxone.</li></ul>
Community Support & Engagement	
<b>Prevent</b>	<ul style="list-style-type: none"><li>» Get involved with your local opioid safety coalition.</li><li>» Work with local hospital on safer prescribing (e.g. through ED or hospital discharge).</li></ul>
<b>Manage</b>	<ul style="list-style-type: none"><li>» Distribute public service announcements for audiences in movie theaters, buses, radio shows, etc.</li></ul>
<b>Treat</b>	<ul style="list-style-type: none"><li>» Participate in local opioid safety coalitions (public health medical societies, hospitals, clinics, law enforcement, judicial system, treatment centers, and advocates).</li><li>» Coordinate referrals and care with external treatment centers (outpatient and residential) and behavioral therapy.</li></ul>

# Appendix

## Measures Identified by Key Informant Organizations

For a full set of measures and definitions corresponding to the CDC Guideline on Prescribing Opioid for Chronic Pain, consult the resource: [Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain](#).

Strategy	Impact	Measure	Source
Prevent	Reduce new start opioid prescriptions	✔ Percent of patients with acute low back pain prescribed opioid	Health Organization
		✔ Percent of patients with opioid prescriptions with no opioid utilization in the prior 90 days	Health Organization
Manage	Decrease number of patients prescribed opioids from escalating to unsafe dosage	✔ Percent of patients with opioid prescriptions in the measurement period whose dosage increased from the prescribed dosage in the 90 days before the first day of the measurement period	Health Organization
	Decrease number of patients prescribed unsafe regimens	✔ Number of patients per 1,000 prescribed daily opioids for longer than 30 days	Health Organization
		✔ Percent of patients on more than 90 MME daily (for more than 30 days)	CDC
		✔ Percent or number of patients per 1,000 simultaneously prescribed opioids and benzodiazepines	CDC
	Identify opioid use disorder; provide appropriate treatment	✔ Percent of patients with documented opioid use/ prescriptions who have appropriate urine drug screening results	CDC
		✔ Number of patients with four or more prescribers or pharmacies	NQF Endorsed
		✔ Percent of patients on chronic opioid therapy who have been screened for substance use disorder	Health Organization
	Reduce inappropriate ED use	✔ Percent of nonfatal opioid overdoses in the ED	<a href="#">California Opioid Overdose Surveillance Dashboard</a>
	Decrease number of patients with addiction	✔ Number of patients diagnosed with opioid use disorder (OUD)	Health Organization

# Appendix

## Measures Identified by Key Informant Organizations *(continued)*

Strategy	Impact	Measure	Source
Treat	Increase access to appropriate treatment	✔ Percent of patients with alcohol or opioid use disorder who receive MAT	Health Organization
	Increase use of buprenorphine for addiction and pain treatment	✔ Number of buprenorphine prescriptions per 1,000 patients	<a href="#">California Opioid Overdose Surveillance Dashboard</a>
		✔ Percent of patients with buprenorphine prescriptions who had opioid prescriptions in the prior 90 days	Health Organization
	Increase provider adoption of MAT	✔ Number or percent of x-waivered prescribers	Health Organization
		✔ Number or percent of new x-waivered prescribers writing buprenorphine prescriptions	Health Organization
	Increase MAT program enrollment, engagement, retention	✔ Percent of patients with opioid use disorder enrolled in MAT program	Health Organization
		✔ Average length of stay in treatment	Health Organization
		✔ Appointment show rate	Health Organization
	Improve patient quality of life	✔ Percent of patients with OUD in treatment whose score on Quality of Life Survey increased from previous score	Health Organization
	Stop	Stop Overdose Deaths	✔ Percent of patients with documented opioid use or prescription prescribed naloxone
✔ Percent of patients who used prescribed naloxone			Health Organization
✔ Opioid overdose death rate			<a href="#">California Opioid Overdose Surveillance Dashboard</a>

# Appendix

## Resource List

### Data / Transparency

- » [California Opioid Overdose Surveillance Dashboard](#)
- » [California County Fact Sheets: Treatment Gaps in Opioid-Agonist Medication Assisted Therapy](#)
- » [IHA MY18 Value-Based P4P and Medicare Stars Measure Set](#)
- » [Overcoming Data-Sharing Challenges in the Opioid Epidemic: Integrating Substance Use Disorder Treatment in Primary Care](#)
- » [Reducing Opioid Overuse Dashboard – Medical Group Measures](#)

### Health Information Technology

- » [CURES](#)
- » [Primary Care Clinic Re-Design for Prescription Opioid Management – Common Registry Elements](#)
- » [Prescribing Naloxone: Instructions for health care providers with patient inclusion criteria and billing options](#)

### Workforce Development

- » [The National Center for Complex Health and Social Needs – Online Courses](#)
- » [Primary Care Clinic Re-Design for Prescription Opioid Management](#)
- » [Project Echo Tele-Learning \(NM and CA\)](#)
- » [Six Building Blocks: A Team-Based Approach to Improving Opioid Management in Primary Care](#)
- » [Substance Use Consultation: Online and Telephone](#)

### Clinical Practice

#### Clinical Guidelines:

- » [ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use](#)
- » [Benzodiazepine and Z-Drug Safety Guideline: Tapering and Discontinuation](#)
- » [CDC Guideline for Prescribing Opioids for Chronic Pain and Fact Sheet](#)
- » [Kaiser Permanente Washington: Patients on Chronic Opioid Therapy for Chronic Non-Cancer Pain Safety Guideline](#)
- » [Safe Prescribing for Acute Pain Poster](#)
- » [Statewide Standing Order for Naloxone](#)
- » [Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain](#)
- » [CDPH Prescription Drug Overdose Prevention Initiative “Resources for Opioid Prescribers”](#)
- » [Example Workflows for Adult and Family Medicine](#)
- » [Opioid Stewardship and Chronic Pain: Guide for Primary Care Providers](#)
- » [Partnership Health Plan Provider Training Resources + Tapering Toolkit and Video – The Art and Very Little Science of Tapering](#)
- » [Smart Care California: Resources for providers](#)

#### Prescriber Toolkits:

##### *Chronic Pain Management*

- » [AAFP Chronic Pain Management Toolkit](#)
- » [Alameda County Prescriber Toolkit](#)
- » [CDC Guideline Resources and Clinical Tools + Quality Improvement and Care Coordination:](#)

##### *Medication Assisted Treatment*

- » [ASAM Continuum tool](#)
- » [Integrating Buprenorphine Treatment for Opioid Use Disorder in Primary Care](#)
- » [MATx Mobile App](#)

##### *Overdose Prevention*

- » [Overdose Prevention and Naloxone Manual](#)
- » [Naloxone for Opioid Safety: A provider's guide](#)

# Appendix

## Resource List *(continued)*

### Clinical Practice *(continued)*

#### Screening and Assessment Tools:

- » [SAMHSA Assessment Tools](#)

#### *Pain Assessment*

- » [Pain Assessment Tools](#)
- » [Pain Assessment: Review of Current Tools](#)
- » [Pain Assessment and Documentation Tool: 4 A's](#)

#### *Risk Assessment*

- » [Clinical Opioid Withdrawal Scale \(COWS\)](#)
- » [Drug Abuse Screening Test](#)
- » [National Institute on Drug Abuse Chart of Evidence-Based Screening Tools and Assessments for Adults and Adolescents](#)
- » [Risk Assessment: Safe Opioid Prescribing Tools](#)

### Leadership & Sustainability

- » California Health Care Foundation:
  - + [Opioid Safety](#)
  - + [Opioid Safety Resource Catalog](#)
- » [IHA MY18 Value Based P4P and Medicare Stars Measure Set](#)
- » [Model for Improvement](#)
- » National Quality Partners Playbook: [Opioid Stewardship](#)
- » [Opioid Safety Resource Catalog](#)
- » Smart Care California:
  - + [Focus Area: Opioids](#)
  - + [Reducing Opioid-Related Morbidity and Mortality: Provider Strategies](#)

#### MAT Program Development

- » Center for Care Innovations: [Treating Addiction in the Primary Care Safety Net – Implementing Medication-Assisted Treatment and the Lessons Learned](#)

#### Hospital Partnerships

- » [ED-Bridge Program](#)
- » [Project SHOUT – Support for Hospital Opioid Use Treatment](#)

#### Case Studies

- » [Doctors are Changing San Diego's Opioid Prescribing Practices](#)
- » [Managing Pain During an Opioid Epidemic – Kaiser Permanente National Highlights](#)
- » [Opioid prescribing decreases after learning of a patient's fatal overdose](#)
- » [Safer and More Appropriate Opioid Prescribing: Kaiser Permanente – Southern California's Comprehensive Approach and Research](#)
- » [Tackling Opioid with Clear Prescription Guidelines, Accurate Monitoring, and Provider Education](#)

### Access to Care

- » [CSAM buprenorphine toolkit with home induction worksheets](#)
- » [Integrating Buprenorphine Treatment for Opioid Use Disorder in Primary Care: Home-Based Induction](#)
- » [Opportunities and Challenges to Utilizing Telehealth Technologies in the Provision of Medication Assisted Therapies in the Medi-Cal Program](#)

# Appendix

## Resource List *(continued)*

### Patient Engagement

- » [DiPi Design – Pain Project](#)
  - + [Alternative Treatments Poster](#)
  - + [Controlled Substance and Wellness Agreement](#)
  - + [Introduction to Opioids Patient Booklet & Video](#)
  - + [Outpatient Radio](#)
  - + [Tapering Booklet](#)
- » [Opioids: What you need to know \(infographic\)](#)
- » [Opioid Safety and How to Use Naloxone: A guide for patients and caregivers](#)

### *Medication Assisted Treatment*

- » [ASAM Opioid Addiction Treatment: A Guide for Patients, Families, and Friends](#)
- » [Buprenorphine-Naloxone: What You Need to Know](#)
- » [Treatment Options: Pros and Cons](#)

### Community Support & Engagement

- » [CA Hub-and-Spoke System](#)
- » [California Opioid Safety Network of Coalitions](#)
  - + [Safe Med LA](#)
- » [Outpatient Radio](#)

# Appendix

## Abbreviations

<b>ASAM</b>	American Society of Addiction Medicine
<b>BH</b>	Behavioral Health
<b>CA</b>	California
<b>CAADC</b>	Certified Advanced Alcohol and Drug Counselor
<b>CBT</b>	Cognitive Behavioral Therapy
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CDPH</b>	California Department of Public Health
<b>CHCF</b>	California Health Care Foundation
<b>COT</b>	Chronic Opioid Therapy
<b>COWS</b>	Clinical Opioid Withdrawal Scale
<b>CQC</b>	California Quality Collaborative
<b>CSWA</b>	Controlled Substance Wellness Agreement
<b>CURES</b>	Controlled Substance and Utilization Review and Evaluation System
<b>DiPi</b>	Center for Design in the Public Interest
<b>ED</b>	Emergency Department
<b>EDCHC</b>	El Dorado Community Health Centers
<b>EHR</b>	Electronic Health Record
<b>HRSA</b>	Human Resources and Services Administration
<b>ICD</b>	International Classification of Diseases
<b>IHA</b>	Integrated Healthcare Association
<b>LCSW</b>	Licensed Clinical Social Worker
<b>MAT</b>	Medication Assisted Treatment or Medication Addiction Treatment
<b>MME</b>	Morphine Milligram Equivalent
<b>MY</b>	Measurement Year
<b>NM</b>	New Mexico
<b>OA</b>	Opioid Agonist
<b>ODD</b>	Opioid Use Disorder
<b>P4P</b>	Pay for Performance
<b>PCP</b>	Primary Care Provider
<b>PDMP</b>	Prescription Drug Monitoring Program
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>SUD</b>	Substance Use Disorder
<b>UC</b>	University of California
<b>VA</b>	Veterans' Administration

# Appendix

## References

- » Coffin P, Behar E, Rowe C. Nonrandomized Intervention Study of Naloxone Coprescription for Primary Care Patients Receiving Long-Term Opioid Therapy for Pain. *Annals of Internal Medicine*. 2016; 165(4): 245-252. doi:10.7326/M15-2771.
- » Demidenko MI, Dobscha SK, Morasco BJ, Meath TH, Ilgen MA, Lovejoy TI. Suicidal ideation and suicidal self-directed violence following clinician-initiated prescription opioid discontinuation among long-term opioid users. *General Hospital Psychiatry*. 2017;47:29-35. doi:10.1016/j.genhosppsych.2017.04.011.
- » Doctor JN, Nguyen A, Lev R, et al. Opioid prescribing decreases after learning of a patient's fatal overdose. *Science*. 2018;361(6402):588-590. doi:10.1126/science.aat4595.
- » Frank JW, Lovejoy TI, Becker WC, Morasco BJ, Koenig CJ, Hoffecker L, et al. Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy: A Systematic Review. *Ann Intern Med*. ;167:181-191. doi: 10.7326/M17-0598
- » Glanz JM, Narwaney KJ, Mueller SR, et al. Prediction Model for Two-Year Risk of Opioid Overdose Among Patients Prescribed Chronic Opioid Therapy. *Journal of General Internal Medicine*. 2018. doi:10.1007/s11606-017-4288-3.
- » Parchman ML, Korff MV, Baldwin L-M, et al. Primary Care Clinic Re-Design for Prescription Opioid Management. *The Journal of the American Board of Family Medicine*. 2017;30(1):44-51. doi:10.3122/jabfm.2017.01.160183.
- » Sharp AL, Shen E, Wu Y-L, et al. Satisfaction With Care After Reducing Opioids for Chronic Pain. *The American Journal of Managed Care*. June 2018:e196-e199.

# Acknowledgements

The following individuals and organizations contributed to the development of this toolkit and generously shared their time, knowledge, and experience.

## Authors:

Crystal Eubanks, MS



Denise Armstorff



## Advisory Group Members:

Amy Nguyen Howell, MD, MBA



Stephen Steinberg, MD



Sharon Isonaka, MD, MS



Madrone Styles, RN, MSN



Kelly Pfeifer, MD



Lisa Ward, MD



Hannah Snyder, MD



Jennifer Wong, MPH



## Interview Informant Organizations:

