SMART CARE CALIFORNIA
Less Waste. Less Harm. Better Care.

February 2019

Curbing the Opioid Epidemic

Checklist for Health Plans and Purchasers

Smart Care California is a public-private partnership working to promote safe, affordable care in California, including a focus on opioid safety and lowering opioid overdose deaths. This checklist of health plan approaches is based on the most up-to-date evidence emerging from literature review, case studies, interviews, and surveys of California health plans. See the California Health Care Foundation's publications, including an online Opioid Safety Toolkit (www.chcf.org/opioidsafetytoolkit), *Changing Course: The Role of Health Plans in Curbing the Opioid Epidemic* and *Why Health Plans Should Go to the "MAT" in the Fight Against Opioid Addiction* for details and references.

Smart Care California is focused on four priority areas with the strongest evidence for impact:

	EXAMPLES OF DATA SUPPORTING GOAL
Prevent. Decrease the number of new starts: fewer prescriptions, lower doses, shorter durations.	➤ Large health plan study showed 67% of members taking opioids for 90 days continued regular use two years later.[1] ➤ Risk of prolonged use of opioids increases by 1% per day over 3 days.[2]
Manage. Identify patients on risky regimens (high-dose, or opioids and sedatives) and develop individualized treatment plans, avoiding mandatory tapers.	➤ Doses >100 morphine milligram equivalents (MME) per day increase the death rate almost ninefold[3] compared to 1 to 20 mg daily. Thirty percent of opioid overdose deaths include concurrent benzodiazepine use.[4] ➤ The CDC recommends against involuntary tapers[5]; involuntary tapers have been shown to increase illicit drug use[6] and suicidal self-harm.[7]
Treat. Streamline access to evidence-based treatment for substance use disorder at all points in the health care system.	➤ Buprenorphine and methadone decrease rates of death, HIV, and hepatitis, and increase retention in treatment compared to social model treatments.[8] ➤ Starting buprenorphine in the emergency department doubles retention in treatment at 30 days.[9]
Stop deaths. Promote data-driven harm reduction strategies, such as naloxone access and syringe exchange.	➤ Co-prescribing of naloxone with chronic opioid prescriptions lowered emergency department visits by 47%.[10] Communities with increased naloxone availability have lower death rates.[11] ➤ Syringe services programs lower HIV and hepatitis transmission and health care costs.[12]

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2. Anuj Shah, Corey J. Hayes, and Bradley C. Martin, "Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015," *Morbidity and Mortality Weekly Report* 66, no. 10 (March 17, 2017): 265–69, doi:10.15585/mmwr.mm6610a1.
3. K. M. Dunn et al., "Opioid Prescriptions for Chronic Pain and Overdose: A Cohort Study," *Annals of Internal Medicine* 152, no. 2 (January 19, 2010): 85–92, doi:10.7326/0003-4819-152-2-201001190-00006.
4. "Benzodiazepines and Opioids," National Institute on Drug Abuse, www.drugabuse.gov.
5. Deborah Dowell and Tamara M. Haegerich, "Changing the Conversation About Opioid Tapering," *Annals of Internal Medicine* 167, no. 3 (Aug. 1, 2017): 208–9, doi:10.7326/M17-1402.
6. P. Coffin, prepublication data analyzing outcomes from opioid discontinuation after long-term use.
7. M. Demidenko et al., "Suicidal Ideation and Suicidal Self-Directed Violence Following Clinician-Initiated Prescription Opioid Discontinuation Among Long-Term Opioid Users," *General Hospital Psychiatry* 47 (July 2017): 29–35, doi:10.1016/j.genhosppsych.2017.04.011.
8. *A Guideline for the Clinical Management of Opioid Use Disorder*, British Columbia Centre on Substance Use, June 2017, www.vch.ca (PDF).
9. Gail D'Onofrio et al., "Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial," *JAMA* 313, no. 16 (Apr. 28, 2015): 1636–44, doi:10.1001/jama.2015.3474; and "Naloxone Decreases the Use of Emergency Room in Patients Taking Opioids for Pain," press release, San Francisco Dept. of Public Health, June 28, 2016, www.sfhealthnetwork.org.
10. "Naloxone Decreases the Use of Emergency Room in Patients Taking Opioids for Pain" [press release], San Francisco Dept. of Public Health, June 28, 2016, www.sfdph.org (PDF).
11. Alexander Y. Walley et al., "Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis," *BMJ* 346 (January 31, 2013): f174, doi:10.1136/bmj.f174.
12. D. Vlahov and B. Junge, "The Role of Needle Exchange Programs in HIV Prevention," *Public Health Reports* 113, no. S1 (June 1998): 75–80, www.ncbi.nlm.nih.gov; and "Access to Clean Syringes," Centers for Disease Control and Prevention, last modified August 5, 2016, www.cdc.gov.

Approaches to Decrease New Starts and Support Safer Pain Management

IN PLACE	LOW PRIORITY	HIGH PRIORITY	
			Provider Network
			Offer or support provider education on pain management based on prescribing guidelines (CDC or medical board).
			Offer or support specific programs that help providers safely manage patients on high opioid doses or combinations (opioids and benzodiazepines), avoiding mandatory tapers to arbitrary dose targets.
			Analyze data to identify outlier prescribers and flag for education, coaching, and/or fraud investigation.
			Ensure access to in-network pain specialists aligned with CDC guidelines for peer consultation or secondary case review.
			Create dashboards to measure comparative opioid prescribing rates and work with outlier prescribers; avoid using incentive programs that could encourage involuntary tapers or refusal to treat new opioid-dependent patients.
			Participate in local opioid safety coalitions to support community prescribing guidelines and integration of addiction treatment into health care settings.
			Work with inpatient and outpatient provider network to change preset opioid prescribing order sets, focusing on acute pain management.
			Medical Management
			Remove prior authorization requirement for first course of physical therapy for back pain and ensure timely access to care.
			Add chiropractic services as benefit.
			Add acupuncture services as benefit.
			Add health education or mindfulness resources as benefit.
			Train case managers on common issues in chronic pain and addiction.
			Increase access to behavioral health services for patients with chronic pain.
			Identify members losing prescribers (e.g., prescribers no longer providing opioid management) and coordinate referrals to pain management or addiction treatment where needed. Develop polices to prevent "opioid refugees."
			Pharmacy Benefit (All interventions should have an exception for palliative care.)
			Review dose limit policies to ensure they do not encourage involuntary tapers and ensure prompt clinical review of exception requests to ensure harm does not exceed benefit for individual patients.
			Implement quantity limits for new starts.
			Remove methadone from formulary for pain.
			Set up policies to decrease new starts for concurrent opioid and benzodiazepine use.
			Remove prior authorization requirements for common nonopioid pain medications (e.g., antidepressants, neuroleptics with indications for pain).
			Implement pharmacy and/or prescriber lock program for patients using multiple prescribers, and provide case management to ensure appropriate care and referral to services.
			Member Services
			Provide member education on opioid risks and nonopioid pain management strategies.

Strategies to Increase Access to Addiction Treatment and Naloxone

IN PLACE	LOW PRIORITY	HIGH PRIORITY	
			Provider Network
			Evaluate network adequacy for specialty addiction treatment and develop action plan to meet demand.
			Evaluate network adequacy for primary care addiction treatment (buprenorphine and naltrexone) and develop action plan to meet demand.
			Contract with medication-assisted treatment (MAT) telehealth providers.
			Offer or support provider education on buprenorphine prescribing (e.g., waiver training).
			Offer financial incentives or alternative payment models to encourage primary care providers to treat addiction with buprenorphine.
			Work with emergency departments (EDs) to treat addiction with buprenorphine and refer for ongoing management in ED, and to dispense naloxone to high-risk patients.
			Place navigators or recovery coaches in EDs to help facilitate entry into addiction treatment.
			Work with hospitalists to start buprenorphine or methadone treatment with patients hospitalized with addiction-related diagnoses (e.g., endocarditis or osteomyelitis).
			Work with correctional settings to offer all addiction treatments and care coordination of medical and behavioral needs on re-entry.
			Ensure adequate access to buprenorphine and methadone for pregnant women.
			Work with hospitals to ensure evidence-based treatment of neonatal abstinence syndrome, minimizing medication and NICU use and promoting family unification.
			Incentivize behavioral health integration through pay-for-performance or direct grants; avoid incentive programs that could encourage dismissing patients from opioid treatment or refusing entry for new pain management patients.
			Offer or support provider education on co-prescribing naloxone.
			Work with local opioid safety coalitions to build new MAT access points.
			Medical Management
			Train case managers to guide members to addiction treatment.
			Identify members on high-dose or risky regimens and refer to case management.
			Notify outpatient prescribers about hospital and ED admission for overdose events.
			Minimize copays for addiction treatment (prescriber visits and behavioral health).
			Pharmacy Benefit
			Remove authorization requirements for initiating and maintaining buprenorphine for addiction, including eliminating requirements for detox in lieu of maintenance.
			Remove authorization requirements for initiating and maintaining buprenorphine for pain.
			Work with pharmacy network to support stocking and furnishing naloxone.
			Remove authorization requirements and copays for naloxone.
			Member Services
			Provide member education on naloxone.
			Ensure that members at high risk of addiction or opioid overuse receive outreach from peers, recovery support, or case manager.