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PROVIDER NEWSLETTER

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Contact Us:

(707) 863-4100 ***www.partnershiphp.org***

From the Desk of PHC CEO Liz Gibboney

Focus on Quality – Our Healthcare Quality Initiatives

Ensuring high quality health care for our members is one of our most important organizational goals, right alongside operational excellence and financial stewardship. It also casts the widest net, because we define high quality health care as more than high HEDIS scores and member satisfaction.

High quality also means building the internal infrastructure to successfully attain NCQA accreditation, ensuring timely access to primary and specialty care, partnering with county agencies and community organizations to address social determinants of health, and providing resources to our primary care network in caring for the most vulnerable and chronically ill of our members. Finally, it means developing new programs and redesigned systems of care that acknowledge that health is broader than health care, and we must evolve as well, to do our part in ensuring our members and the communities we serve be healthy.

As part of our continued commitment to quality care, PHC has undertaken a number of ambitious initiatives that will bring more quality care to our members. These include:

California Children's Services (CCS) Redesign: We are engaged with many stakeholders, including families, to develop a flexible system that will provide improved access and care coordination for children and young adults with special needs.

Drug Medi-Cal Waiver: We are developing a regional model to provide access to a high-quality, comprehensive drug treatment benefit for our members.

Health Homes: An extension of our Intensive Outpatient Case Management pilots, the Health Homes Program will serve our members with multiple chronic conditions from physical to behavioral who may benefit from enhanced care management and coordination at sites throughout our service area

Palliative Care Services: Our four Palliative Care pilots are helping inform State policy and program design to provide palliative care services that will be required for all Medi-Cal recipients under SB 1004.

Prospective Payment System (PPS) Redesign: We believe payments to providers needs to support that way in which health care is best provided, and this initiative aims to do just that. The new payment structure will give federally qualified health centers more flexibility on the types of services they provide, such as emails, phone calls, group visits or video visits, which will be critical to improve access, especially in our rural counties.

Many of you have already had a big role in the planning stages of these initiatives, to which I thank you! However, there is still a lot of work to be done, and we will need each of you to help make each quality initiative successful. With your support we can continue to make our communities a healthier. In Partnership,

From the Desk of Chief Medical Officer Robert L. Moore, MD, MPH

The Hazards of Co-prescribing Benzodiazepines and Opioids

Partnership HealthPlan's Managing Pain Safely initiative is approaching the end of its third year, and we have seen about a 74% decrease in the number of patients who take high doses of opioids (>120 mg Morphine Equivalent per Day). In the last phase of this initiative we will be focusing on reducing the most dangerous drug combination associate with many opioid-related overdose: the interaction of opioids and benzodiazepines.

Risks of the Benzodiazepines. In day to day practice, benzodiazepines (BZD) are relatively safe when taken alone and for short-term. Their large therapeutic index allows for increased safety and relatively low potential for overdose deaths when taken independently. However, when combined with opioids, BZD have proven to be very dangerous. In the past five years the U.S. has seen a fivefold increase in the number of unintentional BZD associated deaths. Reviewing data from multiple states, it has been shown that BZD are a leading cause of fatal drug overdoses, second only to opioid analgesics.[2] The increase in BZD and opioid related Emergency Room visits and unintentional deaths has been attributed to the concomitant use of both medications, either illicitly or prescribed.

Despite the data showing the drastic increase in deaths for patients concomitantly using benzodiazepines and opioids, co-prescribing continues to be an alarming trend. It has been shown that taking benzodiazepines is a greater indicator of future long term opioid use than chronic or musculoskeletal pain, with as many as 40% of opioid users also taking BZD. When compared with opioid abusers, patients who take both opioids and BZD are more likely to take the medications for longer periods of time and at higher doses. Concomitant users are also more likely to use or abuse other drugs and have a comorbid psychiatric disorder. This fatal combination has contributed to as much as 80% of unintentional overdose deaths involving opioids.[1] In a study detailing the association between benzodiazepine prescribing and opioid use in US veterans, it was shown that the adjusted hazard ratio for risk from drug overdose for patients currently taking opioids who had a history of taking benzodiazepines was 2.33 (95% confidence interval 2.05- 2.64), and for those who are currently taking both opioids and benzodiazepines the adjusted hazard ratio for risk from drug overdose was 3.86[4].

Risks of Co-Abuse. The rates of BZD use among those who are also taking an opioid agonist, such as methadone or buprenorphine, have been regularly noted in literature. Individuals may be abusing opioids and BZD in order to amplify the euphoric effect of opioids. It has been noted that for individuals participating in methadone maintenance programs, rates of concomitant BZD use have been as high as 70%.[3] For individuals participating in medication assisted treatment for opioid use disorder, it is important to note that there has been evidence that BZD use can remove the protective ceiling effect of buprenorphine on respiration depression. Caution is recommended with patients on opioid replacement therapy- ensure that proper regular screening for alternative drugs/ medications is occurring, and consider using an alternative medication for anxiety relief, such as SSRIs. [3]

Managing Benzodiazepines. Benzodiazepines are most often prescribed for their anxiolytic effects, as well as their adjunctive treatment for several neurological and psychiatric disorders such as seizures and alcohol withdrawal, as well as for their muscle relaxant effects. Opioids and BZD are often prescribed by different physicians, who may or may not be in communication with one another regarding the patient's medication regimen. [1] While assessing risk of co-prescribing, physicians should be aware that BZD pharmacokinetic interactions can be incredibly variable, dependent on multiple factors such as patient age, ethnicity, poly-drug use, and certain medical conditions (such as renal failure). Prior to initiation of a BZD or opioid analgesics, it is important to complete a comprehensive review of patient history, including checking of your state's prescription drug monitoring system (CURES in CA), and a standardized risk stratification tool. It is important to note that in addition to the increasing rates of medically prescribed BZD, the rates of illicitly used BZD, especially in conjunction with opioids, has also been increasing[2].

In starting to prescribe benzodiazepines, consider the above factors and remember that the benzodiazepines are Beer List drugs that should be avoided if possible in the elderly and frail. Below are a number of tips to remember when starting BZD:

Start at the lowest possible dose for the shortest period of time.

Use the formulation best suited to the indication. For instance, use the short acting benzodiazepines for sleep induction. Use the longer acting formulations for chronic daily management of anxiety.

If anxiety is the indication, use short-term (< 6 weeks) as a bridge to more effective anti-depressant therapy (SNRIs, SSRIs, Bupropion)

Use in conjunction with other modalities such as cognitive behavioral therapy, and stress reduction strategies.

continued next page

The Hazards of Co-prescribing Benzodiazepines and Opioids *(continued)*

Do not stop abruptly but establish a taper schedule. Stopping BZD abruptly could potentially be fatal.

Tapering Benzodiazepines. Given the dramatically increased risk of overdose and death with co-prescribing of BZD and opioids, consider tapering to the lowest possible dose or off, of one or both of these high risk medications. Tapering of BZD is fraught with obstacles. Rebound symptoms with heighted anxiety and insomnia is common so longer tapers may be required. CDC recommends tapering opioids first due to the difficulty with BZD tapering. If the patient has memory difficulties that might impair their ability to remember and stay on the opioid taper or the BZD dose is low, consider starting with the BZD taper.

Some considerations for tapering:

- Go slow (3-6 months)
- Expect anxiety, insomnia, and resistance. Provide supportive psychotherapy
- One prescriber, one pharmacy
- Switch from short acting agents such as lorazepam to longer acting agents such as diazepam or clonazepam
- Reduce the daily dose by 5-10% per week
- Early follow-up – 1 week after starting and adjust tapering dose if needed
- Slow taper after ½ of original dose achieved
- Add adjunctive therapy if withdrawal/rebound symptoms are problematic. Drugs to consider are buspirone, clonidine, Vistaril, Inderal

The U.S. Surgeon General has asked every clinician in the United States to be part of the solution to the epidemic of opioid and benzodiazepine related deaths. We ask all our clinicians at the end of 2016 to embrace this, and help our communities to be safer.

Resources:

[1]Gudin JA; Mogal S; Jones JD; Comer SD. "Risks, Management, and Monitoring of Combination Opioid, Benzodiazepines, and/or Alcohol Use". *Post Graduate Medicine*, 2013, 125 (4) 0032-5481

[2]Jann M; Kennedy WK; Lopez G. "Benzodiazepines: A Major Component in Unintentional Prescription Drug Overdoses with Opioid Analgesics". *Journal of Pharmacy Practice*, 2014, 27(1) 5-16

[3]Jones JD; Mogali S; Comer SD. "Polydrug Abuse: A Review of Opioid and Benzodiazepine Combination Use." *Drug and Alcohol Dependence*, 2012, 125(1-2) 8-18

[4]Park TW; Saitz R; Ganoczy D; Ilgen MA; Bohnert ASB. "Benzodiazepine prescribing patters and deaths from drug overdose among US veterans receiving opioid analgesics: case-cohort study". *BMJ Open Access*, 2015, 350:h2698

(Adapted from phcprimarycare.org blog written by Dr. Scott Endsley, PHC Associate Medical Director for Quality)

Annual Disclosure Statement

PHC recognizes the potential for underutilization of care and services and takes appropriate steps to monitor for this. The processes utilized for decision making are based solely on the appropriateness of care and services and existence of coverage. PHC does not offer incentives or compensation to providers, consultants or health plan staff to deny medically appropriate services requested by members, or to issue denials of coverage.

Healthy Kids Program

Effective 12/31/2016 all PHC Healthy Kids (HK) members will have to transition to Medi-Cal or have other health care coverage. All contracts will be terminated as of midnight, 12/31/2016.PHC wishes to take this opportunity to thank all of our HK contracted providers for participating in this program and for the excellent services provided to our HK members. If you have questions, please contact the Provider Relations Department.

Provider Relations Newsletter

Important Numbers - Claims Mailing Addresses

Medi-Cal	Partnership*Advantage*	Healthy Kids	PHC Care Coordination
Attn: Claims Department P.O. Box 1368 Suisun City, CA 94585-1368	Attn: Claims Department P.O. Box 610 Suisun City, CA 94585-0610	Attn: Claims Department P.O. Box 3172 Suisun City, CA 94585-3172	Asthma, Diabetes, ESRD & Growing Together Perinatal Programs - (707) 863-4276

Provider Preventable Conditions (PPCs) Must be Reported

By law, providers must identify and report all provider-preventable conditions that are associated with Medi-Cal claims and that occur during the treatment of Medi-Cal eligible patients. Providers do not need to report PPCs that existed prior to the initiation of treatment.

Providers must complete the one page PPC reporting form (DHCS Reporting Form 7107) for each PPC, and submit it to DHCS for any Medi-Cal beneficiary, even if the provider does not intend to bill Medi-Cal.

In addition, Partnership Healthplan of California requires providers in our network to report PPCs for PHC members directly to PHC. Providers may self-report via telephone call, or e-mail to PQI@partnershiphp.org.

Additional information can be found on the DHCS Website: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx

The form can be found on the Medi-Cal website:
https://files.medi-cal.ca.gov/pubsdoco/Forms/dhcs_7107.pdf

For more information, and to read the full article, visit https://goo.gl/RrsvN1

Provider Relations Corner

CHDP and Referrals to Specialty Care

During a child's preventive exam, issues arise that warrant referral to specialty care. Your office generates a referral via eRAF through our Provider Online Services. In addition to generating a referral, CHDP providers follow up with the child's caregiver that that specialty appointment occurred. Findings should be documented in the child's medical record.

Initial Health Assessment

When a PHC member is assigned to your practice for Primary Care, you are asked to complete an Initial Health Assessment (IHA) within 120 days. This is a requirement of Medi-Cal. We send you a monthly list of new members and address labels to help you contact the member for that first appoinment. Contracted PCPs are to make at least 3 documented attempts to contact the member and schedule the IHA (if necessary). Contact methods include at least one attempt by phone attempt and one by mail. Maintain a record of your attempts for site review by

Information Technology Department

Health Information Exchange

Health Information Exchange (HIE) is the transmission of healthcare-related data among facilities, health information organizations (HIOs) and government agencies according to national standards. In Q3-2016, PHC Board has approved funding to develop HIE Infrastructure within PHC to receive clinical data from various regional HIEs and other sources to improve quality of care and reduce cost of care. Some key examples of data that we expect to receive include Admission/Discharge/Transfer Notifications, Laboratory Data, Radiology Reports, Hospital discharge summaries, Clinical Summary (Continuity of Care Document or CCDs) which includes Allergies, Problems, Medications, Lab Results, Immunizations, etc. Based on current plan, technology resources will be procured by Q1-