



# Managing Pain Safely: Multiple Interventions to Dramatically Reduce Opioid Overuse

Partnership HealthPlan of California's Approach to Reduce Opioid Misuse and Abuse

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## **EXECUTIVE SUMMARY**

Policy makers and public health experts are struggling to develop strategies for countering the burgeoning problem of prescription opioid overuse, abuse, diversion, and related mortality. Amidst this struggle, many not-for-profit health plans have leveraged their control over medication payments and strong relationships with the prescriber community to rapidly and substantially reduce opioid misuse. The approach of the Partnership HealthPlan of California (PHC, or “the Partnership”) is a helpful case study, and emphasizes the importance of health plans’ infrastructure and processes regarding opioid prescribing as a key public health strategy to quickly turn the epidemic around.

Using the Model for Improvement methodology, PHC developed a framework to begin addressing the problems related to opioid use/misuse. In January 2014, internal workgroups of specific focus areas were convened (i.e., pharmacy, provider network, community initiatives, member services/care coordination/ utilization management, policy and communication, and data management) to begin planning and executing targeted initiatives. From January 2014 to December 2015, PHC has seen a 48% decrease in the total opioid prescriptions per 100 members per month. Partnership believes that the Managing Pain Safely program can be used as a template to standardize approaches in addressing opioid misuse and abuse across the country.

### **About Partnership HealthPlan of California**

Partnership HealthPlan of California is a non-profit public health plan that was established in 1993 in Solano County, California. PHC, designated as a County Organized Health System (COHS), is a community-based health care organization that contracts with the State of California and local counties to ensure that children and adults with limited income and resources can receive medical services at little or no cost. With six offices in four locations in Eureka, Fairfield, Redding, and Santa Rosa, the Partnership provides quality health care to more than 560,000 Medi-Cal members throughout 14 Northern California counties, including Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo.



In accordance with PHC's mission, "To Help Our Members and the Communities We Serve Be Healthy," the Partnership is dedicated to continually improving the quality of care our members receive and ensuring that they have access to the highest quality health care available.

As a COHS, PHC is strategically positioned to implement progressive quality improvement initiatives which lead to systemic, network-wide change. With low administrative rates of less than 4%, PHC is able to offer a higher provider reimbursement rate and support community initiatives. The COHS plan also allows for local governance that is sensitive and responsive to each local area's healthcare needs. PHC nurtures community involvement, inviting advisory boards to participate in collective decision making regarding the direction of the plan.

A comparison of prescription opioid utilization rates in PHC's 14 counties, as compared to statewide and national data, led PHC to recognize that a communitywide improvement program needed to be implemented to tackle the widespread use/misuse of opioids. At the same time, PHC evaluated claims data to fully understand the magnitude of the problem within our service area. In January 2014, PHC officially launched the Managing Pain Safely program, which established an interdepartmental framework that links PHC to the community we serve.

Partnership acknowledges that there is an effective use of opioids for treating pain, when medically indicated, both acutely and chronically (such as palliative care and cancer patients). Managing Pain Safely's initiatives and policy changes are not meant to eliminate all opioid use, but rather reduce the amount of opioid use when not medically appropriate. It is PHC's intention to support our providers adequately and properly treat acute and chronic pain, being cognizant of the potential for the pendulum to swing too far in the other direction, underutilizing opioids and ineffectively treating pain for the members we serve.


## **INTRODUCTION**

The Partnership HealthPlan of California (PHC) Managing Pain Safely (MPS) Initiative is working to improve the health of PHC members by ensuring that prescribed opioids are for appropriate indications, at safe doses, and in conjunction with other treatment modalities.

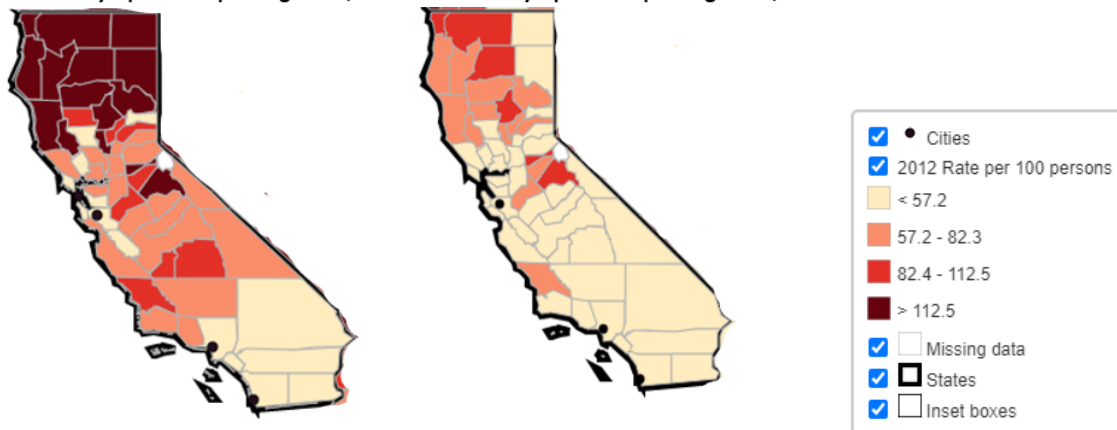
After years of recommendations for prescribers to treat pain as the 5th vital sign, evidence has begun to accumulate regarding the dangers of prolonged use of opioids. In 2010, the CDC released findings depicting the dangers of long term opioid use, and government organizations began recommending limiting the use of opioids in chronic, non-cancer, terminal pain.

Based on this research and findings, PHC is working with our communities to increase awareness of the importance of safe prescribing of opioid medicine. Our overall goal is to prevent escalating doses of opioids for patients already on high doses and to assist clinicians in our network prescribe opioids safely and appropriately.

## **EPIDEMIOLOGY**

In 2018, an average of 41 people died each day from overdoses involving prescription opioids, totaling nearly 15,000 deaths.<sup>(1)</sup> While the overall national opioid dispensing rate declined from 2012 to 2019, dispensing rates continued to remain very high in certain areas across the country. Opioids are still the predominant driver of drug overdose deaths accounting for almost 70% of all drug overdose deaths. Of all opioid overdose deaths, 2/3 involve synthetic opioids other than methadone such as tramadol and fentanyl.<sup>(2)</sup> 

U.S. County Opioids Dispensing Rates, 2012      U.S. County Opioids Dispensing Rates, 2018



In 2019, 5% of U.S. counties had enough opioid prescriptions dispensed for every person to

have one. While the overall opioid dispensing rate was 46.7 prescriptions per 100 persons, some counties had rates that were six times higher than the overall rate.<sup>(3)</sup>

The overall opioid use is not only concerning when discussing the potential of overdose and death, but also when taking into account the decrease in quality of life and functionality that is a common outcome of high-dose opioid use. Studies have shown that long-term opioid use impacts multiple organ systems and causes an overall decrease in quality of life of the patient for non-cancer chronic pain patients<sup>(4)</sup>. In addition, evidence is now surfacing that prescription opioids are a gateway drug for heroin use. Studies have shown that as many as 80% of heroin users took prescription opioids prior to their heroin use<sup>(5)</sup>. In 2018, the number of heroin-involved overdose death rates was more than 7 times higher than 1999 and nearly a third of all opioid deaths involved heroin<sup>(6)</sup>.

In order to thwart the threat and dangers in heroin use and overdose deaths in the United States, organizations need to work to eliminate inappropriate prescribing of opioids and coalesce community efforts to shift cultural norms related to prescription opioid use. Statistics show that primary care providers are the single highest opioid prescribing group in the United States, writing 48.6% of opioid scripts. This is contrasted with pain specialists, who only write 3.3% of opioid scripts<sup>(7)</sup>. Partnership's review of the data led to the firm belief that it is imperative that providers and health care organizations acknowledge both the potential for overdose and the significant potential adverse effects when assessing the appropriateness of prescription opioids. It is vital that both immediate-release and extended-release opioids are regulated to safeguard the health of patients. Studies have shown that 50% of patients who use short-acting opioids for 30 days in the first year remained on these medications during the 3 year follow-up period<sup>(8)</sup>.

Partnership is uniquely positioned to directly impact and guide provider prescribing habits. Evidence shows that long-term prescription opioid use can have significant adverse effects and can be potentially life threatening. PHC's Managing Pain Safely program was developed to reduce the volume of members inappropriately taking prescription opioids, support best-practice prescribing habits among our providers, and shift cultural norms within the communities we serve. Partnership acknowledges that there is an effective use of opioids for treating pain, when medically indicated, both acutely and chronically (such as palliative care and cancer patients). Managing Pain Safely's initiatives and policy changes are not meant to eliminate all opioid use, but rather reduce the amount of opioid use when not medically appropriate.

## **STATE OF THE SYSTEM**

The evidence presents a dark picture and illuminates the consequence of a broken system. The use of opioids for medicinal purposes is not a new concept. Opioids for medicinal use has existed for centuries, with varying amounts of regulation. In the 1920s, the non-medical use of opium was outlawed. Fifty years later, in the 1970s, the Controlled Substances Control Act loosened the

restrictions on prescribing opioids as defined by those previous laws. This act was an impetus to the trends we are currently seeing in opioid prescribing and use throughout America (7)

In conjunction with the newly available long-acting opioids, pharmaceutical companies heavily marketed opioids starting in the 1970s. These factors contributed to the drastic increase in opioid use seen between the 1970s and 1990s. During the same time period, increased focus was placed on the treatment of pain. In 2000, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) released new pain management standards, highlighting a patients' right to have pain treated adequately (5)

Aggressive marketing by pharmaceutical companies propagating the unfounded evidence of “no-upper-limit” of opioid use further perpetuated the broken system (5). As laws were liberalized to increase the availability of prescription opioids, the number of Americans receiving these prescriptions skyrocketed. Due to lack of knowledge regarding the long-term effects of opioid use, there was widespread misconception of the safety of opioids and inadequate training of prescribers. For years providers were taught that opioids were safe and necessary to adequately treat pain. The addictive properties and adverse effects of these drugs were not widely known until late in the 20<sup>th</sup> century and early in 21<sup>st</sup> century. By the time evidence of the risks began to surface, the healthcare industry and Americans across the country were deep into a prescription opioid epidemic. The norms within provider practices and homes in America had been set. Opioids had been deemed safe and appropriate to use on a long-term basis, creating the current public health crisis of opioid misuse/abuse.

## **REDEFINING A BROKEN SYSTEM: MANAGING PAIN SAFELY**

### **Managing Pain Safely Framework**

In 2013, key leaders and staff at PHC began evaluating internal and external opioid data. The problem was presented to the executive leadership team, the Physician Advisory Committee and the Board of Directors. All agreed that there was a drastic need for a strategic initiative aimed at curtailing opioid use/misuse. PHC began to evaluate best practices from across the country and brainstorm local solutions. Using quality improvement practices and the Model for Improvement methodology, PHC recognized that the first step was to develop an internal framework and alter internal processes related to opioid use. Throughout the project planning, PHC looked to incorporate processes already in place (such as, a pharmacy lock-in program and a concentrated focus on reducing overuse of OxyContin—efforts that have been in place for approximately 10 years), while strategically developing internal policies and processes to enhance efforts already underway. In January 2014, the Managing Pain Safely (MPS) project was officially launched.



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The MPS project management team evaluated the impact of opioid use on each department within Partnership, recognizing and documenting primary and secondary drivers. This evaluation process was used to develop a program structure consisting of five internal workgroups, a steering committee, and a project management team. Each workgroup was tasked with developing an internal driver diagram which was used to map the work activities for the group. Workgroups and their respective areas of focus were defined as follows:

- **Pharmacy:** Identification of interventions that can improve internal/external prescription processes to reduce opioid overuse.
- **Provider Network:** Evaluation of innovative delivery mechanisms, enhanced processes to reduce opioid overuse, and improved equitable access to alternative treatments throughout all PHC regions.
- **Care Coordination/ Utilization Management/ Member Services (CC/MS/UM):** Identification of internal interventions and staff support and/or education to enhance CC/MS/UM processes regarding opioid overuse and chronic pain.
- **Legislative Policy/ Media/ Communication:** Identification, organization, and coordination of venues and platforms for raising awareness, conducting education, ensuring regulatory compliance, developing written communication, and affecting legislative changes regarding opioid overuse.
- **Community Work Group:** Leadership and/or representation for the initiation/support of community workgroups, activities, and community engagement initiatives for the purpose of information sharing, and delivery of technical assistance and resources regarding opioid overuse.

After the first year of project implementation, a sixth workgroup was developed.

- **Data Management Workgroup:** Oversight of data collection, sharing, and integration, and maintenance and provision of technical assistance to develop measures related to the MPS project.

Each workgroup was responsible for relevant tasks, decided on by workgroup members, and vetted by the MPS Steering Committee. The steering committee acted as the overseeing body and approved large initiatives. The steering committee consisted of the project management team, workgroup leads, and select PHC executive leadership staff. Each workgroup and the steering committee meet monthly.

The essence of the Managing Pain Safely project at Partnership has been collaboration. The effort was truly collaborative, and the work of each workgroup impacted and directed the path forward for other workgroups. The MPS initiative would not have achieved the same results without the dedicated work from all departments. Internal initiatives executed by these



workgroups were also implemented in the department process and structure, leading to the sustainability of the Managing Pain Safely program.

### **Aim and Measures**

An initial task of the MPS program was to develop an aim statement and outcome measures. The aim statement and outcome measures were defined as follows:

#### **Aim Statement:**

By December 31, 2016, we will improve the health of PHC members by ensuring that prescribed opioids are for appropriate indications, at safe doses, and in conjunction with other treatment modalities as measured by a decrease in:

- Total opioid prescriptions PMPM
- Initial opioid prescriptions PMPM
- Proportion of opioid users with escalating dose
- Proportion of opioid users on greater than 120 mg. MED

#### **Outcome Measures:**

Measure	Measure Type <i>(Outcome, Process, Balance)</i>	Description/Specs <i>(include definition of numerator/denominator where appropriate)</i>	Data Source	Target
Total prescriptions	Outcome	<b>Rate of Opioid prescriptions per member per month</b> = Total Prescriptions/Member Months x pending # of members	MedImpact, Amisys	75%
Initial prescriptions	Outcome	<b>Rate of initial opioid prescriptions per member per month</b> = Initial Prescriptions/Member Months x pending # of members  "Initial" Defined: Opioid utilization in the measurement period with no utilization in the 90 days before the first day of the measurement period	MedImpact, Amisys	50%

Measure	Measure Type (Outcome, Process, Balance)	Description/Specs (include definition of numerator/denominator where appropriate)	Data Source	Target
Prescription Escalations	Outcome	<p><b>Percentage of total opioid users with escalated dose in measurement period</b></p> <p>Denominator = All members on opioids during the measurement period (current month plus previous 90 days) that have at least 84 days of medication prescribed</p> <p>Numerator = Members in the denominator with a dose escalation during the measurement period</p> <p>“Escalation” Defined: Member with average total daily dose (TDD) during the measurement period that is 5% or more higher than the most recent average TDD in the 90 days prior to the first day of the measurement period</p>	MedImpact	90%
Unsafe Dose	Outcome	<p><b>Percentage of total opioid users on a dose &gt; 120 mg. MED</b></p> <p>Denominator = All members prescribed opioids during the measurement period</p> <p>Numerator = Members in denominator whose prescribed average TTD was &gt; 120 mg. MED</p>	MedImpact	75%

### Health Plan Policy Changes

In order to reduce excessive and/or inappropriate prescribing of opioids and limit the flow of patients becoming dependent on long-term, high-dose opioids, PHC instituted formulary and policy enhancements in October 2014. PHC evaluated data pertaining to prescribing habits and trends within the provider network. An analysis of the data revealed that 4 of the top 20 most costly medications prescribed were opioids. The top drug distributed (by volume) to PHC members was Vicodin. The MPS Pharmacy Workgroup leveraged this data to plan and implement a series of formulary and prior authorization changes.

Planning and implementation of these formulary enhancements occurred in three stages. In each stage, PHC scrutinized the process for:

1. Justification for high doses of **expensive** opioids
2. **Escalation** of high-dose opioids (no matter what the price)
3. All prescriptions for all **stable** high doses of opioids

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The initial formulary enhancement in October 2014 focused on reducing dose increases to opioid prescriptions that provide little to no benefit. Initial enhancements were as follows:

- A restricted quantity limit was placed on all PHC formulary opioids for each single-dose strength, not to exceed a maximum daily dose of 120 Morphine Equivalent per Day (MED). (These doses were calculated using the Global RPH Calculator.)
- Reflecting these new quantity limits, Morphine 100mg and 200mg extended release tablets were designated as non-formulary.
- Methadone concentrate and Methadone 40mg tablets were also designated as non-formulary.
- Additionally, a “refill-too-soon” policy was implemented, which requires at least 90% of the prescription’s daily supply to have elapsed before an opioid prescription is able to be refilled.

In April 2015, a second formulary enhancement focusing on prescriptions for all stable high-dose opioids was implemented. Process changes accompanying this enhancement included a request for the following:

- An explanation for all stable, high-dose opioids;
- Additional documentation for specific difficult cases; and
- A “taper plan” for all patients on high-dose opioids, who did not have a justification for continuing a stable dose, documenting the proposed process and steps to be utilized to decrease opioid dosage.

In order to track high-dose patients and treatment plans, a registry of all high-dose patients was created.

Beginning April 2015, the following formulary enhancements were made:

- Formulary Additions:
  - Fentanyl patches 12 and 25 mcg/hr were added to the formulary for patients who have a history of prior opioid use (not for “opioid naïve” patients).
  - Duloxetine was made formulary, adding: Duloxetine 20mg, Quantity limit #60/30 days; Duloxetine 30mg, Quantity limit #60/30 days; Duloxetine 60mg, Quantity limit #30/30 days.
- Non-Formulary Changes:
  - Alprazolam was made non-formulary for new starts.
  - For Methadone 5mg tablets, a quantity limit was implemented; changed from #6 tablets/day to #3 tablets/day.
  - Methadone 10 mg tablets was made non-formulary for new starts only. Prior to April 2015, patients on stable methadone doses of less than 30 mg/day (120

MED) were allowed to continue without prior authorization. Prior authorization was required when the dose exceeded 30 mg/day (120 MED). All patients taking greater than methadone 30 mg/day (120 MED) were required to obtain prior authorization.

- Schedule II, III, IV prescriptions fills were limited to a 30-day supply/fill.

In 2016, we made the significant formulary change to limit immediate-release opioid dispensing

- Immediate-release opioid quantity limit:
  - Implemented quantity limit for immediate-release opioid medications to no more than 30 tablets per 90 days.

In addition to formulary changes, PHC considered other policy changes to support members. Studies have shown that patients who have limited access to alternative treatments have a higher rate of prescription opioid use <sup>(8)</sup>. For this reason, PHC implemented a set of enhanced benefits in conjunction with the April 2015 and 2016 Formulary Enhancements. Select members now have additional benefits, including chiropractic, acupuncture, podiatry, and osteopathic manipulation therapy.

### **Other Interventions**

In conjunction with PHC's formulary and policy changes, many other interventions were implemented that were aimed at provider support, member support, community awareness, and data driven change. These interventions are highlighted below.

### **Provider Support and Prescribing Practice Reforms**

***Provider Network Survey:*** The provider network survey assessed gaps in knowledge and outlined key areas of support needed within the provider network. The results of this survey have been used throughout the MPS project to plan educational events and provide information to fill gaps and support providers.

***Educational Events:*** Since the MPS project launched, PHC has hosted four in-person trainings and five webinars. In total, more than 500 providers, clinic staff, PHC employees, and key community stakeholders have attended the educational events, which offered a total of 25.75 free continuing medical education (CME) credits.

***Project ECHO:*** Project ECHO (Extension for Community Health Outcomes), offered through UC Davis, provided training to PHC primary care providers regarding advanced skills in caring for patients with chronic pain. The first Project ECHO for chronic pain started in 2014, with the

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first three cohorts funded through the California Healthcare Foundation. PHC began splitting the funding cost in 2015. Attendance of the training program was as follows:

- Session 1- Three clinics in the PHC network attended
- Session 2- Ten clinics in the PHC network attended for the first time; 2 PHC clinics in the PHC network attended as repeat participants

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- Session 3- Six clinics in the PHC network attended for the first time; 12 clinics in the PHC network attended as repeat participants

After Sessions 1 and 2, two-thirds of the participants who responded to the survey indicated they were working to taper patients on high-dose opioids and more than half of participants noted that, as a result of Project ECHO, they were less likely to prescribe opioid medications. *When asked how Project ECHO has impacted the way participants prescribe high-dose opioids, one provider stated “We have better tools and better plans for how to manage pain patients.”* For more information regarding Project ECHO’s chronic pain training, please visit the [Project ECHO website](#).

**PCP Quality Improvement Program and Pharmacy Quality Improvement Program (Pay-for-Performance Incentives):** Through the PCP and Pharmacy Quality Improvement Programs (QIP), PHC offers multiple pay-for-performance incentives related to the MPS program, including:

**PCP Incentives:**

- ***Buprenorphine Qualified Providers:*** New or existing credentialed buprenorphine prescribers, who are willing to take outside referrals, are eligible for a \$500 incentive (up to a maximum of 5 per site).
- ***Urine Toxicology Screening:*** Measures the percentage of members on chronic pain medications who have had a urine toxicology screen during the measurement year. The incentive offered is dependent on the provider site’s number of capitated members, the proportion of its chronic pain patients screened, and its overall performance in the QIP relative to other sites’.
- ***Peer-led Support Groups:*** Provider sites are eligible for \$1000 per group, per year, for hosting peer-led support groups. Provider sites are encouraged to host groups related to chronic pain management and/or opioid dependence.

**Community Pharmacy OIP Incentives:**

- ***Chronic Pain Medication Oversight Measure:*** Pharmacies are asked to develop a protocol for screening customers for inappropriate/illegal opiate use, which includes criteria for the use of CURES (California’s Prescription Drug Monitoring Program). Each pharmacy can receive 10 points for this measure (out of 100 points), if it is completed.

**340B OIP Incentives:**

- ***Safe Use of Opioids Outcome and Process Measures:*** Entities are asked to develop and submit outcome and process measures related to safe use of opioids. Some examples include:

- Process measures have included ensuring a certain percentage of patients have an up-to-date pain contract/agreement, and increasing the percentage of patients with recent urine toxicology screenings.
- Outcome measures have focused on decreasing the number of patients taking unsafe doses of chronic opioids.

**The** 340B QIP uses a withhold system whereby PHC will hold 20 percent of a 340B Participating Entity's Pharmacy Benefit Manager (PBM) paid amount. Reporting on the Safe Use of Opioids Measures accounted for 30 points or 30 percent of the repayment. If a 340B participating entity submitted its quarterly report and it was approved by PHC's chief medical officer, that entity would receive the 30 percent tied to those measures.

**Naloxone Program:** PHC is supporting provider sites to develop and implement site-level Naloxone programs. PHC is working with providers to prescribe Naloxone, in conjunction with opioids, for high-risk patients. PHC has funded the purchase of 2000 nasal atomizers to be distributed for use in this program. PHC continued to support Naloxone prescribing and enhance support of community efforts related to Naloxone.

**Tele-consult Program:** PHC is partnering with Synovation Medical Group to pilot a peer telephonic consultation program for primary care providers. The program will allow providers the opportunity to discuss clinical cases, obtain answers to questions about pain management, and receive recommendations regarding pain medications, including opioid management.

**Integrated Care Clinic Planning Project:** Through a grant funded by the California Healthcare Foundation, PHC is partnering with two clinics in our region to develop a payment plan for implementing and sustaining integrated behavioral health/substance use clinics at primary care sites. PHC will disseminate best practices and look to scale up once the plan is finalized.

**MPS Webpage/ Toolkit:** The Managing Pain Safely Toolkit, which can be found on the [Managing Pain Safely webpage](#), was developed for providers and includes successful practices, PHC prescribing guidelines, training videos and tutorials, dose calculators, and tapering guides.

**Formulary Enhancements:** Formulary enhancements were implemented to safeguard our members from the overuse and misuse of opioids. The formulary enhancements and implemented prior authorization processes are a tool to avoid the escalation of total opioid dose. (Please see "Health Plan Policy Changes" section above and Appendix III for detailed information of PHC's opioid quantity limits and restriction table.)

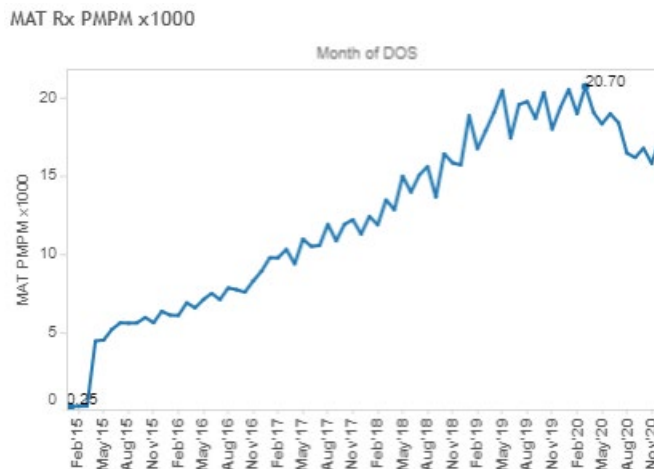
**Pain Management Registry:** Clinical data is tracked for members who are using high-dose opioids. Examples of the type of data tracked include prescribing physician, medication and dose patterns, behavioral health diagnosis, and behavioral health treatment. Registry source data is comprised of pharmacy treatment authorization request data and claims data.



**Pain Management Oversight Committees:** Pain management oversight committees support clinicians caring for patients with chronic pain by providing evidence-based advice on managing pain safely, including the use and management of controlled substances (including opioids), use of adjunctive therapy (including behavioral health and physical modalities), and appropriate referrals to interventional pain specialists. PHC sponsors an oversight committee for providers in our network who do not have access to a local oversight committee.

**Safe Use Now:** The Safe Use Now program was utilized to rate providers' prescribing practices based on 17 risk factors. Individual ratings were shared via peer-to-peer conversations with PHC's medical directors and more than 350 providers, with the intention of highlighting areas for improvement and influencing prescribing habits.

**Integrated Clinics:** PHC promoted having PCPs obtain X-waivers and to integrate MAT into the Primary care setting. The number of X-waivered prescribers has increased steadily in our region, according to federal data. Use of MAT in our region is shown in the following graph:



**MPS Provider Site-Level Data Sharing:** Continue to share provider site-level data. We had a pilot of sharing information regarding emergency department visits related to opioid intoxication and/or addiction with primary care physicians. Generating this data was labor intensive and did not result in many interventions, so it was discontinued.

### Member Support and Connection to Resources

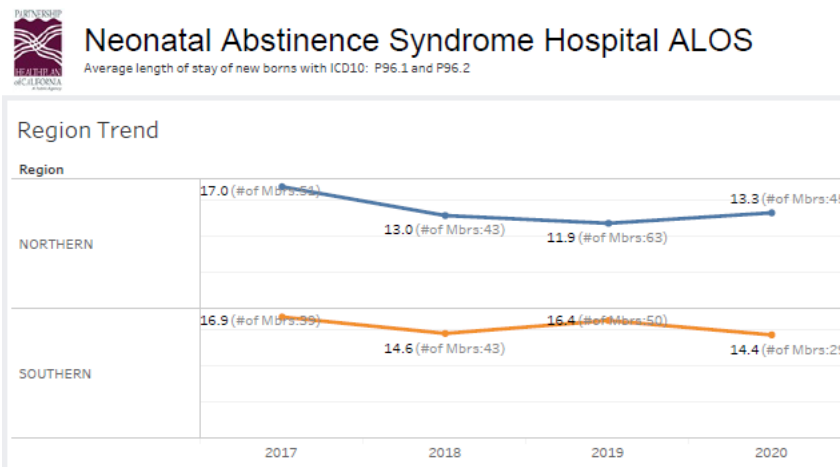
**OUCH Process:** PHC has trained staff to support network providers and to help members with chronic pain. These staff members form the OUCH (Outreach and Understanding Can Help) team. This necessary, proactive step was taken to support the members as we were making internal changes. Please see Appendix IV for OUCH workflow.

**Taper Guide/Patient Journal:** Development of a Taper Guide for members and Taper Toolkit for providers supported providers tapering their patients. These materials were developed in response to provider requests for additional material and resources to be used while guiding a patient through the tapering process.

### Community Awareness and Norm Shift

**Local Community Coalitions:** PHC has been actively working at the ground level to support communities. A key focus has been quality improvement and community engagement coaching to form collective impact coalitions throughout the 14 PHC counties. This was eventually achieved in all counties for at least some period of time. Coalitions have become less active in recent years, a trend accelerated by the COVID-19 pandemic.

**Perinatal Opioid Exposure:** In 2017 to 2019, PHC promoted a change in the way neonates were treated for exposure to opioids. The approach was primarily educational, sponsoring a large convening on the topic featuring the pediatrician who pioneered this evidence base: Dr. Matthew Grossman. We subsequently publicized the CMQCC standards of care in caring for pregnant women using opioids. Our NICU length of stay due to opioid withdrawal was reduced by this educational campaign. Further comparative data and chart reviews of outliers help further this change. This has been written up in detail by the California HealthCare Foundation: <https://www.chcf.org/blog/opioid-dependent-newborns-get-new-treatment/> and also <https://www.chcf.org/event/addressing-opioid-exposure-pregnancy-best-practices-women-newborns/>



### Data Driven Change

**Data Analysis:** PHC developed a process to collect and analyze MPS outcome data. The MPS

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Data Management Workgroup vetted both the data source and the methodology behind data calculation. Data validity and data adjustment remains an ongoing time and resource intensive activity.

**Data Sharing:** In an effort to share provider site-level data, which indicates patient dose and dose pattern, the MPS project has developed two data sharing processes:

1. Voluntary request of provider-site data from provider site; and
2. Peer-to-peer data sharing wherein PHC medical directors outreach to provider sites who have 15 or more patients on high-dose opioids.

## **KEYS TO SUCCESS**

The success of the Managing Pain Safely program resulted from hard work and coordination across all departments within PHC. The following activities greatly contributed to our success:

**Set an Aim:** The first step in tackling a project this large was to set an aim statement in order to pinpoint what we wanted to accomplish and establish the scope of our project. Internal stakeholders were included in the development of the aim statement, which unified the team from the onset. The effort was truly strategic and coordinated, bringing in players from across PHC and the network at large.

**Collaborate, Coordinate and Communicate:** Each MPS initiative impacted multiple stakeholders from different backgrounds. True collaboration takes extensive coordination and communication, both internally and externally. Facilitation of the coordination and collaboration is vital, so it is essential to have project manager tracking all work being accomplished and communicating to each workgroup. Additionally, it is important to ensure key players are at the table. Cross-sector participation should be incorporated into any internal or external coalition or action team. Key components of the communication approach are outlined below:

- **Internal communication** is essential. To further facilitate and enhance internal communication, ensure senior leadership buy-in and commitment.
- **External communication** must be standardized, comprehensive, and in advance of major initiative implementation. To ensure buy-in, ask for input in the planning process and engage key stakeholders in the communication plan.
- **Personal testimonials** are helpful in the communication process and facilitate the engagement of stakeholders. When asked about patient's experiences due to the implementation of the MPS project, one provider shared:

*"I have a few patients who have done very well on Suboxone. One patient whose girlfriend died of an overdose came to me, was dealing with abuse of opioids and is [now] doing remarkably well on Suboxone. [This patient is] taking certain measures to deal with pain non-pharmaceutically and is also getting more stable work and housing."*

- **Utilizing interns** as a part of the collaboration process can be helpful. Local universities often have interns looking to partner for research projects and master's thesis. Interns could prove to be a valuable source for data analysis.

**“Refill too Soon” Policy:** PHC believes that the Refill too Soon policy is a best practice that ensures members are not receiving an extra prescription throughout the year.

**Identify Specific Metrics:** In order to truly report results, specific data metrics are required. To ensure quality data, it is important to include a trained data analyst, if possible. Additionally, it is vital to choose measures where data is easily and reliably accessible.

**Community Support:** Altering prescribing habits is essential to begin to curb the opioid epidemic; however, it is not sufficient in thwarting inappropriate opioid use. A shift in cultural norms and utilization trends needs to occur at the community level. PHC has recognized that joining existing efforts and being a catalyst to promote new community efforts is key.

**Enhanced Offerings for Alternate Modalities to Treat Pain:** The addition of alternative treatment and medication provided additional options when looking to treat pain. The addition of Duloxetine to the formulary for the treatment of pain is one example of a necessary alternative to opioids.

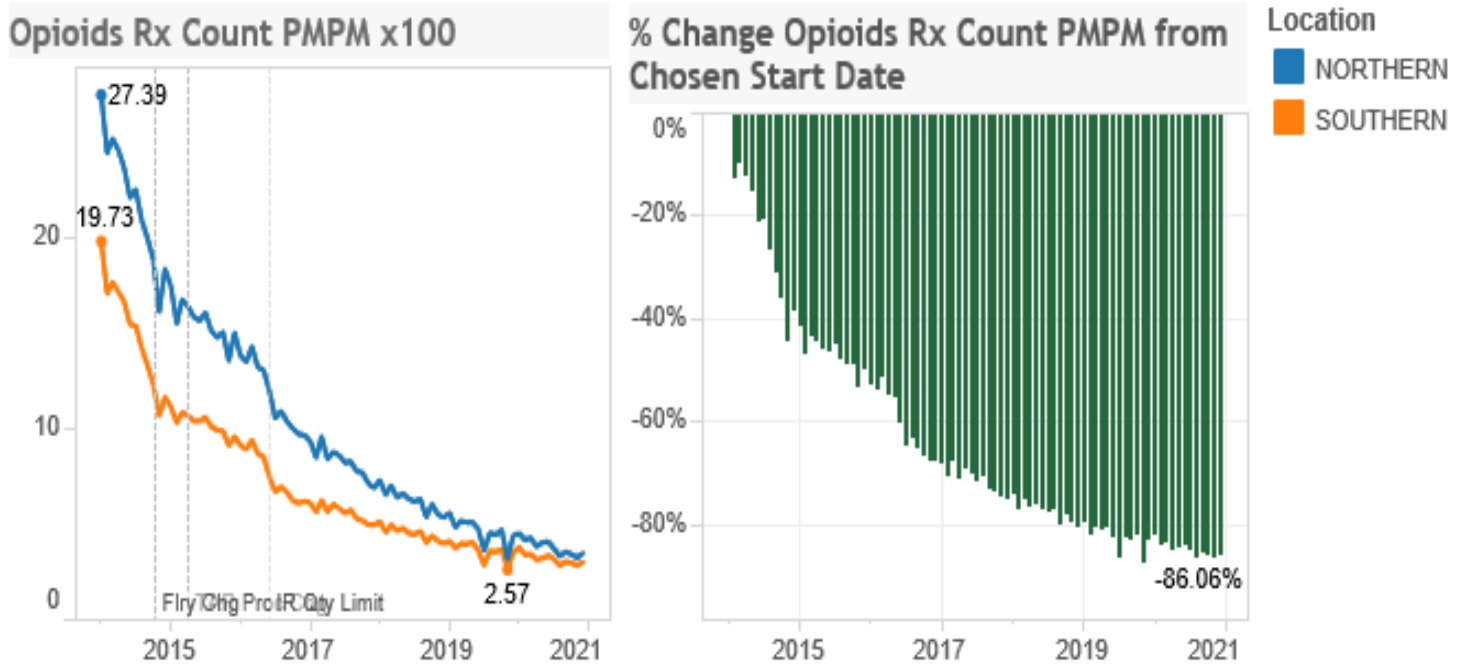
**Celebrate Success:** As you begin to see results, it is essential to celebrate success. This celebration not only solidifies support for continuing the work for additional years, but also assists in shifting culture and allowing organizations and project participants to see pride in their work.

## **DATA AND RESULTS**

Data has been evaluated and analyzed for three of the four outcome measures. Results during the measurement period of January 2014 (project induction) to December 2020 are as follows:

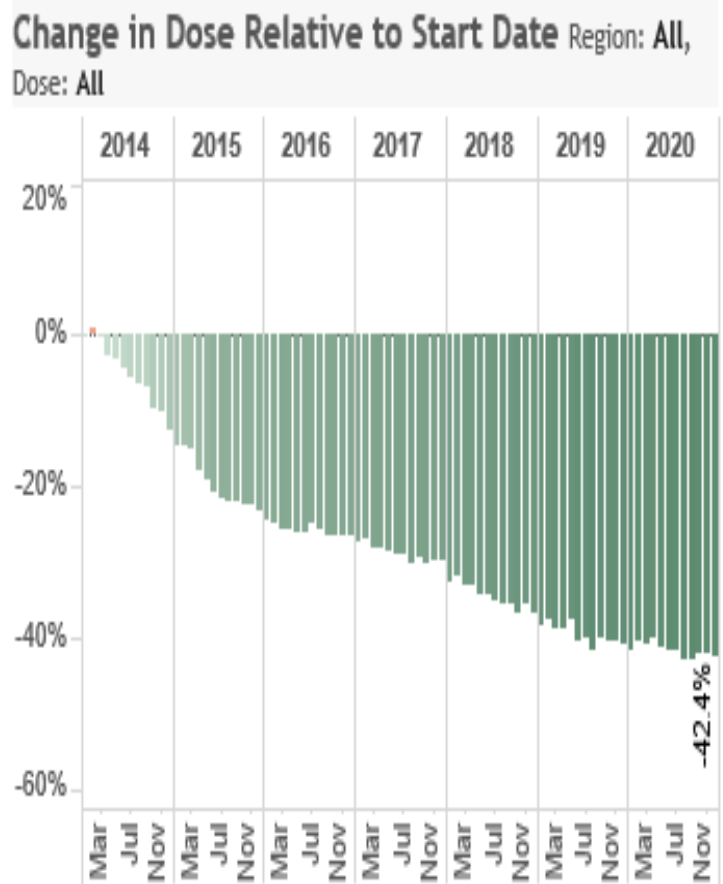
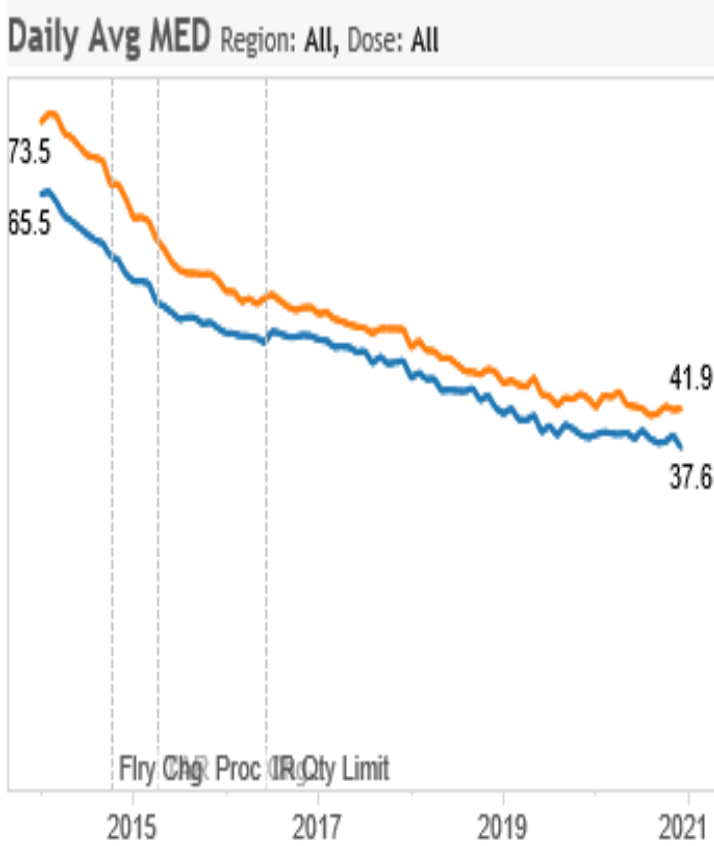
- 86% reduction in total opiate fills per 100 members per month, plan-wide
  - 42% reduction in total MED PMPMx100, plan-wide
  - 83% reduction in initial opiate fills per 100 members per month, plan-wide
-

*Opioid Prescriptions P100MPM*



2014-2020: -86% Decrease, plan-wide for Rx count PMPM since inception of the MPS program in 2014

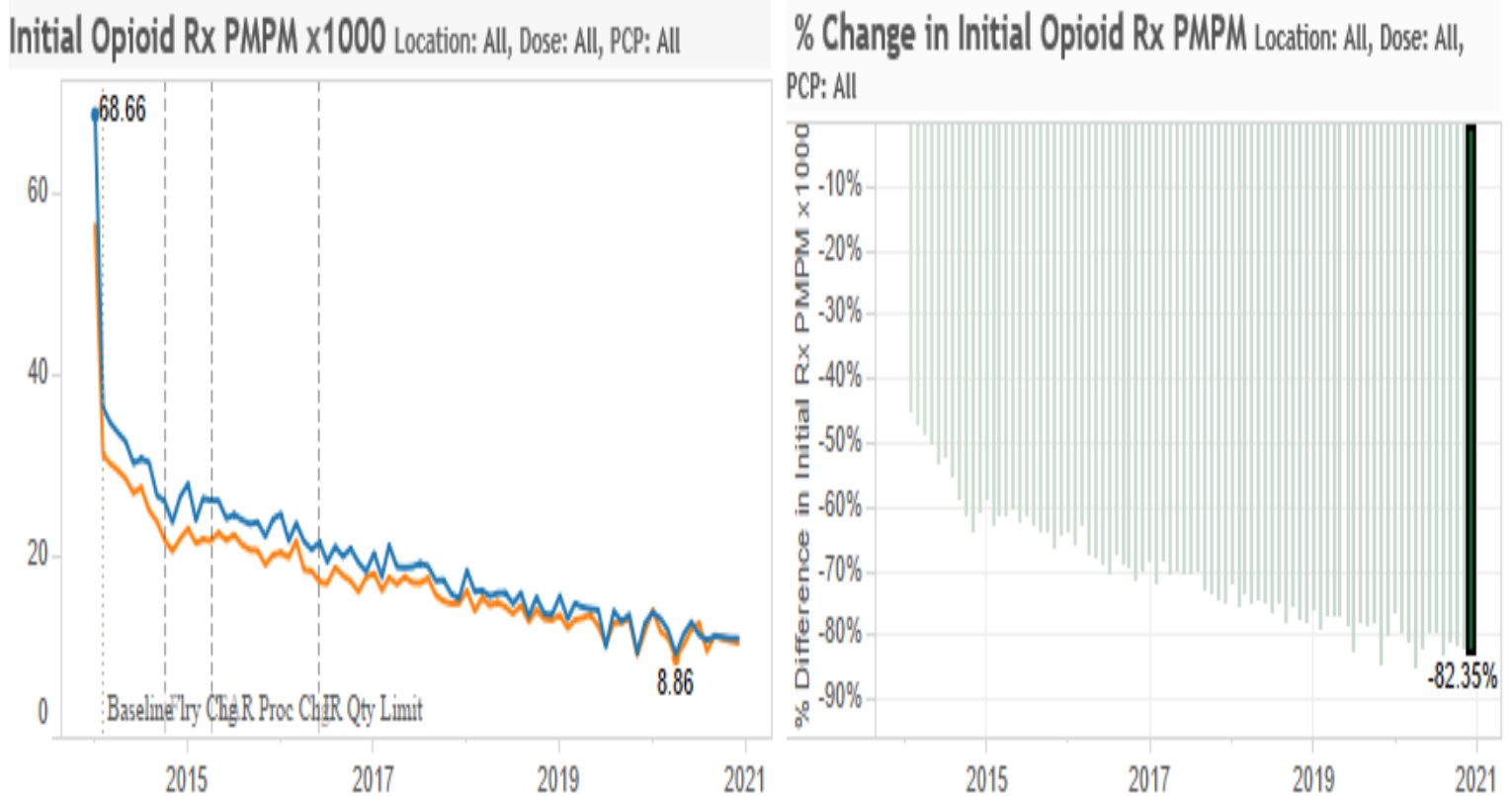
Daily MED



2014-2020:-42% Decrease, plan-wide Total MED PMPM x 100 since inception of the MPS program in 2014



Initial Opioid Prescriptions



2014-2020: -82.35% Decrease, plan-wide in initial Opioid Rx PMPM since inception of the MPS program in 2014

**NEXT STEPS FOR MPS**

Partnership HealthPlan has moved to a maintenance phase for the MPS initiative. Our pharmacy team still reviews TARS for opioids not meeting our pre-authorization limits. The volume of such reviews has decreased steadily as the provider network has become accustomed to these limitations, but it still represents approximately 20% of all pharmacy TAR reviews. Some opioid coalitions continue to meet; PHC participates in these meetings.

In our communities, the opioid use and overdose deaths have continued to increase, even as prescription opioids have decreased, reflecting a transition to use of heroin and fentanyl, the latter of which is more potent and now less expensive than previously.

## **CONCLUSION**

Prescription opioid misuse and abuse has been deemed a national epidemic. Health care organizations across the nation are searching for ways to curtail the rising usage rates and opioid related fatalities. In order to adequately address the problem, a comprehensive campaign needs to be launched, employing primary, secondary, and tertiary interventions.

Providers need further support to induce safer prescribing habits and rewrite the rhetoric related to chronic opioid use. Reforming prescribing habits and standardizing guidelines will aid in cutting off the flow of patients into the pool of opioid dependent individuals.

Community coalitions are key in reframing the narrative and shifting cultural norms related to prescription painkiller use. By utilizing community coalitions to bring together key stakeholders including providers, pharmacists, law enforcement, patient advocates, and behavioral health professionals, comprehensive, all-inclusive change can be accomplished.

Health care organizations need to advocate for the tapering individuals on high levels of opioids and promote the use of substance use disorder and medication assisted treatment for individuals who are currently dependent. In order to fully support individuals suffering from SUD, full integration of behavioral health services into treatment is essential.

Finally, access to the lifesaving antidote, Naloxone, has been proven to save lives. Providers should consider prescribing Naloxone in conjunction with opioids for high risk patients, and community based organizations should assess ways to increase access to Naloxone throughout the community.

Partnership HealthPlan of California believes that a comprehensive campaign like the Managing Pain Safely program can be a template utilized across the country to lower the rates of opioid misuse and abuse, in turn lowering the total mortality rate related to opioid use. The MPS

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framework can be adapted and adopted to fit individual organizations' needs. To effectively stem the inappropriate use of opioid medication, nationwide standardization of efforts and comprehensive collaboration, coordination, and communication will be essential.

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## APPENDICES

### Primary Care & Specialist Prescribing Guidelines

#### **Introduction**

Partnership HealthPlan is a County Organized Health System covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in 14 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have launched a communitywide initiative to promote safer use of opioid medications.

Why is this important? In the last decade, the death rate from opioid overdose has quadrupled, making opioid overdose as common a cause of death as motor vehicle accidents. For every overdose death, there are 130 people who have a long-term dependence on opioids and 825 individuals using opioids non-medically. These numbers originate in prescriptions for opioid pain medications, written by health professionals, so health professionals must work together to reverse this trend.

Based on his/her skill level, the PCP should prescribe appropriate analgesics when indicated for the initial management of pain. In starting analgesics for new onset acute pain, the possibility the acute process will evolve into a chronic pain syndrome should be kept in mind. Chronic pain is defined as pain lasting longer than normally expected for the healing of an acute injury or tissue inflammation, usually in the range of 3-6 months. In this guideline, we are not addressing chronic pain associated with cancer or a terminal disease, conditions in which treatment goals and needs are different than in chronic non-cancer pain.

Use of opioid pain medications for chronic non-cancer and non-terminal pain should be weighed carefully by any prescriber. Chronic use of opioids is associated with an increased risk of addiction, habituation, and tolerance. When combined with alcohol use or with other sedating medications such as benzodiazepines and muscle relaxants, opioid use is associated with an increased risk of accidental overdose and motor vehicle accidents. In addition, chronic use of opioids in high doses can cause opioid-induced hyperalgesia, which ultimately generates increased pain and debility. Unlike acute pain or pain related to metastatic cancer or end-of-life care, the goal of opioid therapy in chronic noncancer, non-terminal pain is improved functioning, not necessarily elimination of pain.

The following standards for opioid use in patients with chronic non-terminal, non-cancer pain are suggested as a starting point from which each community in our PHC region can develop their own standards, for the good of our members and the community.

#### **Recommendations**

**For all opioid prescriptions, write as intended to be taken (i.e. One tablet q 6 hrs prn. (this is a max of 4 per day); or 1-2 q 4-6 hrs but no more than 4 per day (also a max of 4 per day))**

- A. Acute pain. The main goal is to treat pain without creating opioid dependency, tolerance, or hyperalgesia.
1. Preferentially use non-narcotics as first line therapy, especially acetaminophen or NSAIDs. Remember to be cautious with NSAIDs in seniors and persons with hypertension and azotemia.
  2. Restrict use of narcotic pain medications to situations with more severe pain, e.g. traumatic injuries, and if prescribed, limit their use to short periods.
  3. Discuss the risk of opioid dependence, tolerance, and hyperalgesia with patients being initiated on opioid treatment.
  4. Before initiating opioid therapy for acute pain, assess for risk of opioid abuse/diversion using a standardized tool (see appendix for an example). If patient is at high risk, consider a baseline urine toxicology screen and focus on the use of non-opioid modalities to treat pain. Patients between 18 and 25 years of age are at increased risk of abusing prescription drugs, so patients in this age range should be screened carefully.

B. Chronic pain in patients with a remote history of malignancy, but currently in remission, should be treated the same as those with chronic non-cancer pain (see next section).

C. Chronic non-cancer, non-terminal pain

1. Chronic non-cancer, non-terminal pain not responding to non-opioid treatment modalities may benefit from chronic use of low dose opioid medications. This should be weighed against the risk of abuse and diversion. Use of a standardized Opioid Risk Tool should be considered.
2. Most experts world-wide advocate a maximum dose of 120 mg oral morphine equivalents daily (MED) to decrease the risk of overdose and opioid-induced hyperalgesia. This does not mean doses should be escalated to this point in all patients. Many are well-controlled at lower doses. PHC recommends this 120 mg MED limit be used as a community standard. MED calculators are readily available online to convert any narcotic dose to its morphine equivalent. A good one is available at <http://www.globalrph.com/narcotic.cgi>. When patients already at 120 mg MED report insufficient pain control, the dose of opioids should not be increased further. A frank discussion with the patient on the risks of doing so should be conducted.
3. Other treatment modalities should be considered (if not previously utilized), including acupuncture, PT, massage, exercise, counseling, etc.
4. In neuropathic chronic pain, consideration should be given to the use of agents such as tricyclic antidepressants (e.g. amitriptyline or nortriptyline) and anticonvulsants (e.g. gabapentin or carbamazepine).
5. Emphasis should be placed on functional status as opposed to complete elimination of pain, which is often not possible.
6. For patient safety, intramuscular and intravenous opioids should not be administered for chronic, non-cancer, non-terminal pain.

D. Chronic non-cancer, non-terminal pain already on opioid doses greater than 120 mg MED.

1. Should not have their opioid dose increased further.
2. Should have their opioid dose decreased, by one of the following methods:
  - a. Steady tapering of dose to 120 mg MED or lower. The exact tapering protocol will depend on the medication used, the dosage, and other factors.
  - b. Substitution with buprenorphine (Suboxone) by a prescriber experienced in the use of this medication
  - c. Combination of the above with involvement of a multidisciplinary team, including behavioral health and physical therapy, and non-opioid medication

options. The goal is to optimize functional status as opposed to complete alleviation of pain as the latter is often not possible.

- d. Reducing the opioid dose to a safer range can be time-consuming, and it requires both a discussion with the patient about the reasons why this reduction is needed and a clear, well-communicated plan for how this will happen. It is not advisable to allow the patient to decide whether to remain on an unsafe opioid doses. It should be mandatory. Whatever the policy around marijuana, if it is implemented clinic-wide and regionally, then patients will not be able to switch to a different clinician who would allow continued unsafe dosing.
- e. In larger practices or in communities, consider establishing a “chronic pain review committee” to review cases where greater than 120 mg MED are requested, if other exceptions to the institutional policy are considered, and to review clinical management of difficult cases. This helps support clinicians with responding to difficult patients and gives good support for peer review, if a patient has an adverse outcome.

E. Routine monitoring of patients on chronic opioid therapy. The following monitoring standards for patients on opioid therapy should be used by all clinicians in PHC regions.

1. Have a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.
2. Have a signed medication use agreement with the prescriber or prescribing office, renewed yearly.
3. PHC recommends clinicians have a policy which explicitly addresses the use of marijuana in chronic pain when opioids are to be prescribed. Increasingly, pain specialists and PCP practices ask patients to choose between opioids or marijuana for chronic pain. If the patient wants to use medical marijuana for chronic pain, they are not prescribed opioids and if they are prescribed opioids, their tox screens are expected to be negative for marijuana. If the community agrees on this standard, it will minimize patients switching to a different clinician in hopes of finding a different approach.
4. Regularly check the CURES database in all patients being prescribed opioids, preferably each time a prescription is being authorized. At a minimum, the CURES database should be checked annually. If a finding on the CURES report is not consistent with the patient’s history, PHC recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur.
5. Have at least three office visits yearly for chronic pain patients using opioids.
6. Limit each opioid prescription to 28 days (exactly four weeks), writing this on the prescription (e.g. “must last 28 days”). Writing for a 28-day quantity and making sure this is scheduled for a Tuesday, Wednesday, or Thursday every 4 weeks, reduces the problems of refills being sought on weekends or holidays, and requests for early refills because the patient will be running out on a weekend day (which will happen frequently if prescriptions are written for a 30-day supply).
7. Develop an office policy on consequences of breaches in the medication use agreement. Consider a tiered approach, depending on the breach. Examples of different tiers include: warning, modification of prescription frequency, reduced dosage of medication, cessation of medication, and discharge from practice.
8. Monitor for sedation that would make driving motor vehicles unsafe, particularly if opioids are combined with other sedating medications, alcohol, or other substances. If the patient is potentially unsafe to drive a motor vehicle, recommend to the patient they not drive if impaired and consider reporting the patient to the Department of Motor Vehicles (DMV) for evaluation. Note that a stable dose of opioid alone has not been shown to decrease reaction time, but if a patient is involved in a motor vehicle accident



while taking an opioid, the use of the opioid may be used by law enforcement or attorneys to attribute blame. At times prescribers have come under fire in situations like this.

9. Prescribe naloxone to patients at risk of overdose. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental death. See [www.prescribetoprevent.com](http://www.prescribetoprevent.com) for details.
10. Partnership HealthPlan as the capacity to restrict an individual patient to using a single pharmacy and a single prescriber for controlled medication. This is done at the request of the physician. If you have a patient you would like to request restricted status, call the pharmacy department at PHC at 707-419-7906, and we will initiate the process.

**Example of Maximum Daily Recommended Oral Doses of Opioids  
(90 mg MED)  
(For chronic, non-cancer pain)**

**(Before use of any comparative dose data for patient use, please refer to listed reference below for dosing calculator)**

<b>Drug (Generic Name)</b>	<b>Mg</b>	<b>Low Cost Generic Available?</b>	<b>Brand Name Examples</b>
Morphine (PO) Chronic	60	Yes	MS Contin, Avinza (Long Acting)
Codeine (PO)	400	Yes	
Hydrocodone (PO)	60	Yes	Norco (short acting only)
Hydromorphone (PO)	15-30	Yes	Dilaudid (short acting)
Levorphanol (PO) Chronic	2	Yes	LevoDromoran
Methadone (PO) Chronic	10	Yes	
Oxycodone (PO)	20-40	Short Acting:yes Long acting: no	Oxycontin (long acting)
Oxymorphone (PO)	20-40	No	Opana, Numorphan ( short acting generic available but not low cost)
Tapentadol (PO)	150	No	Nucynta
Tramadol	50	Yes	Ultram
Buprenorphine Transdermal	5,10,20mcg /hr	Yes	Butrans
Meperidine	75-100	Yes	Demerol
Fentanyl	25	Yes	Duragesic

<http://www.globalrph.com/narcotic.htm>

**Other Guidelines for Safe Opioid Prescribing**

Dental Guidelines  
Emergency Room Guidelines  
Community Pharmacy Guidelines

**Key Points from Other Guidelines**

1. Emergency Departments should
  - a. Check a CURES report on every patient who will receive an opiate prescription.
  - b. Limit use of opioids for acute pain, especially if there a high risk of abuse and in adults under the age of 25.
  - c. Limit opiate prescriptions to 4 days duration.
  - d. Notify the PCP when an opiate is prescribed.
2. Dental Guidelines
  - a. Use NSAIDs instead of opioids for dental pain (opioids no better than placebo).
3. Community Pharmacies should
  - a. Check a CURES report for all new opioid prescriptions.
  - b. Notify the PCP if there is a prescription pattern suggesting abuse or misuse.
  - c. Check the photo ID of any patient picking up an opioid prescription.
  - d. Counsel patients on the risk of tolerance, addiction, opiate-induced hyperalgesia, and drug overdose

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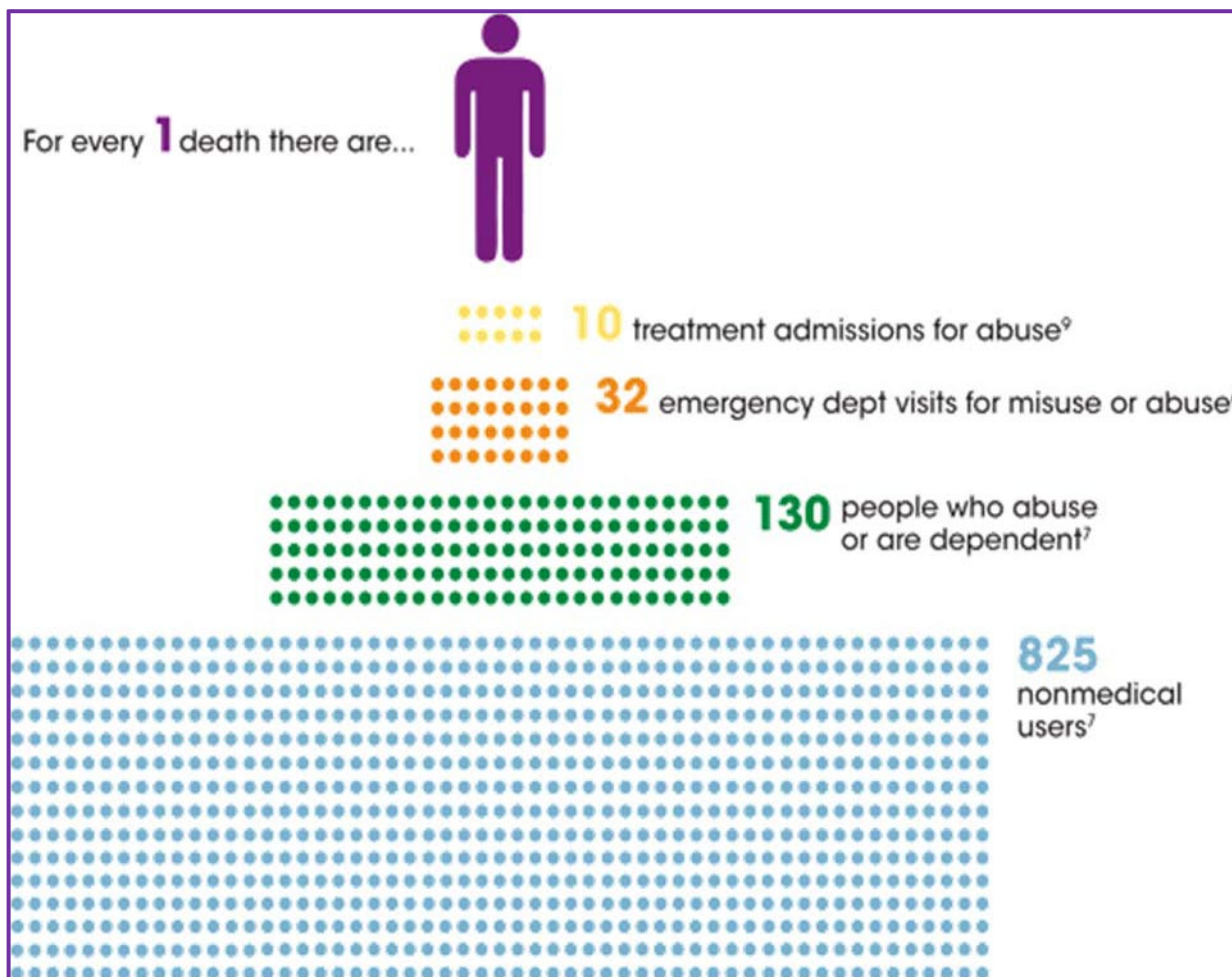
## Appendix A

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

### OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder	[ ]	2	2



CDC statistics (2008)

**Why we have shared responsibility to ensure safe opioid prescribing!**

## Functional Pain Scale

(developed by Kaiser Health Plan)





## Emergency Department Guidelines

### **Introduction**

Partnership HealthPlan is a County Organized Health System covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in 14 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have launched a communitywide initiative to promote safer use of opioid medications.

Why is this important? In the last decade, the death rate from opioid overdose has quadrupled, making opioid overdose as common a cause of death as motor vehicle accidents. For every overdose death, there are 130 people who have a long-term dependence on opioids and 825 individuals using opioids non-medically. These numbers originate in prescriptions for opioid pain medications written by health professionals, so health professionals must work together to reverse this trend.

The emergency department has two key roles in helping with community-wide efforts to control opioid overuse: (1) insuring acute pain is treated in a way that decreases the probability of future over-use of opioids and (2) working closely with primary care clinicians to ensure a coherent, safe approach to treating chronic pain. PHC recommends the following to achieve these goals:

### **Recommendations**

- A. Check a CURES report on all patients who will receive opioid medications. If there is a discrepancy, consider contacting the relevant pharmacies to confirm information, as occasionally the CURES data is not accurate.
- B. Limit opioid prescriptions for Acute Pain. Avoid opioids if pain is not severe or if there are risk factors for substance use disorder (including age 16-45). If opioids are prescribed, use low doses for short courses.
- C. Do not prescribe opioids in the ED for chronic non-malignant pain.
- D. Do not prescribe opioids for poorly defined pain (e.g. fibromyalgia, “everything hurts”, pain not fitting any clinical syndrome)
- E. Do not prescribe controlled substances for patients with high risk of substance use disorder or diversion. Examples include:
  - 1. Patient goes to an emergency room outside of the community they live in.
  - 2. Patient paying cash for ED visit.



3. Patient reports they are on a chronic opioid prescribed by an out-of-area prescriber, who cannot be reached.

4. Patient says their medications were lost or stolen.

F. Refer patient to PCP instead of prescribing refills of existing opioid medications.

G. If the PCP cannot be contacted to do a refill, limit opioid refills to a 4-day supply maximum.

H. Notify PCP if an opioid prescription is given, especially if it is a refill.

I. Call pharmacy to verify medication history on intoxicated patients.

J. Perform a urine toxicology screen on a patient before prescribing a controlled medication, to be sure the result is consistent with the patient's medication history. Consider a confirmatory serum test if the results of a tox screen are unexpected, because false positive and negative screening results are common.

K. Prescribe high dose NSAIDs for acute dental pain (studies show opioids are inferior for dental pain, and no more effective than placebo).

L. If patients come to the emergency room for severe, breakthrough pain on any regular basis, develop an agreed-upon treatment plan with the Primary Care Physician or usual prescribing outpatient physician to avoid such visits.

M. For patient safety, intramuscular and intravenous opioids should not be administered for chronic, non-cancer, non-terminal pain.

### **Other Guidelines for Safe Opioid Prescribing**

Dental Guidelines

Community Pharmacy Guidelines

Primary Care & Specialist Prescribing Guidelines

### **Key Points from these other guidelines**

1. Experts world-wide advocate a maximum dose of 90 mg oral morphine equivalents daily (MED), to decrease the risk of overdose and opioid-induced hyperalgesia. This does not mean doses should be escalated to this point in all patients. Many are well-controlled at lower doses. PHC recommends this 90 mg MED limit be used as a community standard.

2. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.

3. Require a signed medication use agreement with the prescriber or prescribing office, renewed yearly

4. Regularly check the CURES database in all patients being prescribed opioids, preferably each time a prescription is being authorized. At a minimum, the CURES database should be checked annually. If a

finding on the CURES report is not consistent with patient history, PHC recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur.

5. Schedule at least three office visits yearly for chronic pain patients using opioids.

6. Limit each opioid prescription to 28 days, writing this on the prescription (e.g. "must last 28 days"). The 28-day refill, scheduled for a Tuesday, Wednesday or Thursday every 4 weeks, is a best practice, to avoid weekends, holidays, and Friday refills.

7. Prescribe naloxone for patients at risk of overdose. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental death. See <http://prescribetoprevent.org/> for details.

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Opioid Quantity Limit/Restriction Table

GENERIC	STRENGTH	DOSAGE FORM	MAX QTY PER 1 DAY (90 MED limit)	MAX QTY per X Days*
Hydromorphone HCl	2 mg	Tablet	10 tabs	#30 per 90 Days
Hydromorphone HCl	4 mg	Tablet	5 tabs	#30 per 90 Days
Hydromorphone HCl	8 mg	Tablet	2 tabs	#30 per 90 Days
Morphine Sulfate	10 mg/5 ml	Solution	45 ml	240 ml per 90 days
Morphine Sulfate	20 mg/5 ml	Solution	22.5 ml	240 ml per 90 days
Morphine Sulfate	100 mg/5 ml	Solution	4.5 ml	240 ml in 90 days
Morphine Sulfate	15 mg	Tablet	6 tabs	#30 per 90 Days
Morphine Sulfate	30 mg	Tablet	3 tabs	#30 per 90 Days
Morphine Sulfate	15 mg	Tablet ER	6 tabs	#180 in 30 days
Morphine Sulfate	30 mg	Tablet ER	3 tabs	#90 in 30 days
Oxycodone HCl/Acetaminophen	5 mg-325 mg	Tablet	8 tabs	#30 per 90 days
Oxycodone HCl/Acetaminophen	7.5 mg-325 mg	Tablet	8 tabs	#30 per 90 days
Oxycodone	5 mg	Tablet	6 tabs	#30 per 90 days
Oxycodone	10 mg	Tablet	6 tabs	#30 per 90 days
Oxycodone	15 mg	Tablet	4 tabs	#30 per 90 days
Oxycodone	20 mg	Tablet	3 tabs	#30 per 90 days
Oxycodone	30 mg	Tablet	2 tabs	#30 per 90 days
Tramadol	50 mg	Tablet	8 tabs	#90 in 30 days

**\*Explanation of limits:**

IR Opiates, tabs or caps: Except for tramadol, formulary IR oral solid dosage forms (tablets, capsules) are limited to #30 in a 90-day look-back period. Tramadol is an IR opiate exception that allows #90 in a 30-day period.

IR Opiates, oral solution: All are limited to #240 ml in a 90-day look-back.

ER Opiates: Because ER opiates are used chronically rather than acutely, the #30 per 90-day limit is not applied to the ER opiates. Methadone, while not Extended or Sustained Release, is a long-acting opiate and is thus has the same limits as the formulary ER opiates: The monthly (30-day limit) is the 30x multiple of the daily limit.











