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Introduction

The United States is facing an opioid use crisis

Approximately 2.5 million Americans have a substance use disorder related to opioids and heroin.¹ Preliminary data from the Centers for Disease Control and Prevention (CDC) indicate that more than 68,000 people in the United States are predicted to have died from drug overdoses in 2018. This is an improvement from the 2017 predictions as the opioid epidemic gains necessary national attention.

There are many contributing factors to the crisis – such as co-occurring mental health disorders and evolving advice on the management of chronic pain, to note just two – making it complex to solve. However, efforts by providers to reduce potentially hazardous prescribing when alternatives exist and improve care for those receiving opioids will make a difference.

Goal of this playbook

Quality improvement initiatives, as well as treatment resources, should be shared as a way of addressing the crisis. As such, the goal of this playbook is to do exactly that – document quality improvement activities and provide ready access to resources that providers may find beneficial to help further support their patients. It is our hope that the playbook sparks a discussion about prescribing patterns and managing patients who receive opioids.

Key inputs

The Centers for Disease Control and Prevention (CDC) has provided refreshed guidance on opioid prescribing. The central tenants to the CDC’s guideline are use of non-opioid therapies, start low and go slow, and follow-up with patients who have been prescribed an opioid.

A page on The CDC Guideline for Prescribing Opioids for Chronic Pain website (https://www.cdc.gov/drugoverdose/prescribing/guideline.html) outlines what’s included:

- Initiating and managing opioids prescribed for chronic pain
- Opioid selection, dosage, duration, follow-up, and discontinuation
- Assessing risk and addressing harms of opioid use

The CDC issued a resource to offer primary care providers, practices, and health care systems a framework for managing patients who are on long-term opioid therapy (https://www.cdc.gov/drugoverdose/prescribing/qi-cc.html). In addition, they released the Opioid Guideline App (https://www.cdc.gov/drugoverdose/prescribing/app.html), which includes a Morphine Milligram Equivalent (MME) calculator and prescribing recommendations.

In response to the CDC’s guidelines, the Surgeon General of the United States issued a comprehensive report that includes discussions on neurobiology, prevention, treatment, and recovery.

The Surgeon General’s Spotlight on Opioids brings together opioid related information from the ‘Surgeon General’s Report on Alcohol, Drugs, and Health’ into one location to better inform the public on the national opioid crisis (https://addiction.surgeongeneral.gov/).

State-based Prescription Drug Monitoring Programs (PDMPs) are an important tool in managing the opioid epidemic since they may provide a comprehensive look into the prescriptions written for your patients. Each state has a unique website and rules associated with the PDMP. The PDMP Training and Technical Assistance Center (pdmpassist.org/) provides a state-by-state view.

Continuing Medical Education (CME)

The CDC offers a series of webinars regarding opioid prescribing for chronic pain. The webinars are available on the CDC Guideline for Prescribing Opioids for Chronic Pain page (https://emergency.cdc.gov/coca/calls/opioidresources.asp). Some of these courses, such as one titled Dosing and Titration of Opioids, carry free CME credits. The CDC also offers a new interactive module for health care providers, “Assessing and Addressing Opioid Use Disorder.” This training provides free CME/CE credit and can be found at Assessing and Addressing Opioid Use Disorder (OUD) (https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html). The Substance Abuse and Mental Health Services Administration (SAMHSA) (www.samhsa.gov) provides workshops, publications, and research, as well as buprenorphine and opioid prescribing courses.

Additional CME/CE activities can be found on the National Institute of Drug Abuse website (https://www.drugabuse.gov > Medical & Health Professionals > CME/CE).

Behavioral health screening resources for the medical setting

Screening for mental health and substance use disorders may be indicated prior to some opioid prescribing. Screening may help to identify patients suffering from behavioral conditions and provide an indicator on the appropriateness of recommending cognitive behavioral therapy as a form of pain control. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Human Resources & Services Administration (HRSA) (https://www.hrsa.gov) have compiled a list of the screening tools that are effective in identifying behavioral conditions. The list is available on the SAMHSA website (https://www.integration.samhsa.gov/clinical-practice/screening-tools).

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The most common screeners include:
- Screening, Brief Intervention, Referral to Treatment (SBIRT) to identify potential substance use disorders
- CAGE AID to identify potentially problematic use of drug and alcohol
- Patient Health Questionnaire 9 (PHQ-9) to identify depression

**Drug screening resources for the medical setting**

Providers can choose to screen patients using urine drug tests to detect substances prior to prescribing an opioid for chronic pain. The CDC offers a guide ([https://www.cdc.gov/ncbddd/fasd/documents/alcoholbiimplementationguide.pdf](https://www.cdc.gov/ncbddd/fasd/documents/alcoholbiimplementationguide.pdf)) that includes a brief screening tool and stepped clinical response.

Various specialty societies have issued recommendations regarding screening tests.
- American Pain Society/American Academy of Pain Medicine
- U.S. Department of Veterans Affairs – Department of Defense
  - [http://www.healthquality.va.gov/Chronic_Opioid_Therapy_COT.asp](http://www.healthquality.va.gov/Chronic_Opioid_Therapy_COT.asp)
- American College of Occupational and Environmental Medicine

**Patient education materials**

Discussing the benefits, risks, and alternatives with a patient prior to the initial opioid prescription, can be effective in establishing realistic expectations of pain management. Further, a conversation between provider and patient can help to establish alternative therapies as a viable option to control pain. Prior to prescribing an opioid for a chronic concern, consider having patients sign a contract or agreement ([https://www.fda.gov/media/114694/download](https://www.fda.gov/media/114694/download)) regarding the use of the opioid. A straightforward patient education flyer ([https://www.cigna.com/assets/docs/clinical/900725_Opioid_Customer_flyer.pdf](https://www.cigna.com/assets/docs/clinical/900725_Opioid_Customer_flyer.pdf)) can support the interaction.

A pain plan can help patients improve their quality of life while recovering from an injury. Cigna has developed resources ([https://www.cigna.com/helpwithpain/patients](https://www.cigna.com/helpwithpain/patients)) to educate patients on opioids, and tools to improve the quality of the conversation a patient has with their physician about pain management. These resources include a short video about how one in five people have an increased risk of becoming addicted to opioids.

**Opioid disposal**

Opioids present a risk for unintended use when not consumed for the prescribed purposes. While there are “medication take back” days, providers may consider having a method to dispose of unused opioids in their clinical setting or provide recommendation to their patients for in-home disposal, or provide a recommendation to their patients for in-home disposal. Many prescribers provide patients with a drug deactivation bag at the time the prescription is written, along with education on how to use the medication and the importance of proper disposal. The U.S. Food and Drug Administration (FDA) provides further guidance ([https://www.fda.gov/drugs/ensuring-safe-use-medicine/safe-disposal-medicines](https://www.fda.gov/drugs/ensuring-safe-use-medicine/safe-disposal-medicines)).

**Substance use treatment resources**

SAMHSA’s Behavioral Health Treatment Services Locator ([findtreatment.samhsa.gov/](https://findtreatment.samhsa.gov/)) provides nationwide insight to available services.
SAMHSA has also developed a multimedia tool to support an individual’s decision regarding how to receive treatment, Decisions in Recovery: Treatment for Opioid Use Disorder (http://archive.samhsa.gov/MAT-Decisions-in-Recovery/). In addition to the multimedia tool, a handbook (https://store.samhsa.gov/product/Decisions-in-Recovery-Treatment-for-Opioid-Use-Disorders/SMA16-4993) is available.

Partnership for Drug-Free kids has developed great resources for parents who are needing support and guidance around their child’s substance use (https://drugfree.org/).

**Medication-assisted treatment and the MATx mobile app**

Medication-assisted treatment (MAT) is an evidence-based treatment for opioid use disorder that combines the use of medications with behavioral therapy. SAMSHA has developed the MATx mobile app for providers, which allows immediate access to vital information about MAT for opioid use disorder.

Although MAT treatment is gaining more awareness, it continues to be underused. The slow adoption of this treatment is partly due to misconceptions about substituting one drug for another. Moving from stigma to science is key for treatment of opioid use disorder. For additional information, go to https://www.chcf.org/blog/moving-from-stigma-to-science-in-treating-addiction/.

Find out more about MAT at the SAMHSA website (www.samhsa.gov/medication-assisted-treatment). For more information about the MATx mobile app, visit (https://store.samhsa.gov/apps/mat). Practitioner training is available as well on the SAMHSA website (https://www.samhsa.gov/practitioner-training).

**Overdose prevention**

SAMHSA offers an overdose toolkit (https://www.integration.samhsa.gov/Toolkit_Patient-_Family_Safety.pdf), which includes safety advice for patients and family members.

The CDC provides a brief, patient-friendly tip sheet (https://www.cdc.gov/drugoverdose/pdf/patients/Preventing-an-Opioid-Overdose-Tip-Card-a.pdf) for recognizing the signs of an overdose and how to respond.

Naloxone is a medication approved by the FDA to prevent overdose by opioids. SAMHSA (https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone) and the CDC (www.cdc.gov) provide guidance on when providers should consider including Naloxone as part of a patient’s opioid prescription, such as when the patient:

- Takes high doses of opioids (greater than or equal to 50 MME)
- Has a comorbid condition that may make them at risk for an overdose (for example: breathing disorders, pregnancy, prior overdose, mental health conditions)
- Is currently using a benzodiazepine
- Is completing mandatory opioid detoxification or abstinence programs

**Selected resources**

Many resources exist to support providers and patients in the management of opioids. The following resources have been cited as helpful from the provider perspective:

- Non-opioid treatment for chronic pain (cdc.gov/drugoverdose/pdf/alternative_treatments-a.pdf). CDC guidelines on alternatives to opioids, including pharmacologic, physical, and behavioral therapies, as well as over the counter remedies.
- Addressing the Opioid Crisis in the United States (www.IHI.org > Resources > Publications > Addressing the Opioid Crisis in the United States). Institute for Healthcare Improvement

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report on primary drivers to reduce opioid use and how to create an effective system for safe prescribing.

- Prescribing Opioids for Chronic Pain
  (https://www.cdc.gov/drugoverdose/prescribing/guideline.html) Surgeon General’s pocket card offering guidance on safe prescribing according to CDC guidelines.

- Acute and Chronic Pain Flows. A variety of advisory groups, such as Oregon Pain Guidance, are issuing office-based flow charts
  (oregonpainguidance.org/app/content/uploads/2016/05/Acute-and-Chronic-Pain-flow-sheets.pdf) in order to encourage local adoption.

Quality improvement activities

The following activities were submitted by provider groups that are part of Cigna's Collaborative Care® Accountable Care program. The activities are meant to spark conversation about how a health system or provider practice can focus on improving quality by refining how opioids are prescribed and patients are subsequently managed. Practice type and location are included as identifiers since some actions may be more or less feasible based on available resources or state requirements. If you would like to submit a quality improvement activity to the playbook, please send us an email at Lora.Fisher@Cigna.com
# State and practice specialty quick reference

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<th>Patient education and communication</th>
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Arizona: Multispecialty practice
Focus areas: Pain management, medical record review

- Identify a pain management specialty group to assist in the care of patients with chronic pain and establish standardized referral and follow-up protocols between the groups.
  - Pain specialists should leverage a multidisciplinary approach to management, including alternatives such as physical and cognitive behavioral therapies.
- Review electronic medical records to find patients with a potentially hazardous combination of medications including:
  - Long- and short-acting opioids used concurrently.
  - Any opioid plus a benzodiazepine.
  - Any opioid plus a sleep aid.

Connecticut: Primary care practice
Focus areas: Electronic medical records (EMR), opioid agreement, pain management

- Consult and document the CT-state prescription management program (PMP) in the patient’s EMR before renewing ongoing opioid prescriptions for them.
- Patients with chronic opioid prescriptions must sign an opioid-use agreement, which requires them to take random drug tests and only seek prescriptions for opioids or other controlled substances from the prescriber. If a patient does not adhere to the agreement, their opioid prescription is not renewed.
- For patients who require support beyond what a primary care provider (PCP) can offer, identify a local pain management provider with whom the PCP can collaborate.
- The provider updated the patient’s EMR to allow controlled substance prescriptions to be emailed to pharmacies directly.

Colorado: Primary care practice
Focus areas: Educational forum, pain management

- Establish an educational forum on pain management based on practice-based needs (i.e., number of referrals, conditions that prompted referrals)
- Identify pain management centers in the community that adopt principles of care such as:
  - Physical therapy to include all appropriate modalities, such as exercise and stretching, ergonomic counseling, chiropractic care, design of home therapy programs, yoga, etc.
  - Strong psychosocial support with the assumption that many patients will never be pain free.
  - Use of alternative paths, including acupuncture, meditation, relaxation techniques, guided visualization, biofeedback, etc.
  - Judicious use of pain management medications.
- Refer patients with any of the following criteria to a pain specialist:
  - 50 years of age or less (at provider’s discretion)
  - Use of both long- and short-acting narcotics
  - Use of morphine equivalent to more than 120 milligrams daily
  - Use of concomitant benzodiazepine or hypnotic therapy
  - Any psychiatric diagnosis
- Engage the primary care physician (PCP) as the pain management quarterback when a comprehensive pain management center is not available.
- Refer patients with chronic low back pain for behavioral screening and intervention since there are often mental health concerns associated with this diagnosis.
Florida: Multispecialty practice  
Focus areas: Educational forum

- Engage providers in education regarding the national opioid epidemic, updated CDC guidelines regarding the use of opioids, as well as actionable recommendations on how to amend current prescribing practices.

Maryland: Integrated delivery network  
Focus areas: Substance use screening and treatment

- Screen patients using a tool, such as the NIDA–modified ASSIST (drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen) for a substance use disorder prior to prescribing an opioid for chronic pain.
- In the event of a positive screen, have an identified substance use treatment provider aligned who can consult on proper care and, when appropriate, accept referrals.

New Jersey: Integrated delivery network  
Focus areas: Best practices and provider education

- Develop monthly reports showing practice and prescriber-level performance on a series of metrics related to chronic opioid prescribing, acute opioid prescribing, and benzodiazepine prescribing behaviors.
- Utilize practice-level dashboards to reflect performance and share across the system; data is blinded.
- Gather resources and make them easily available to providers across the delivery system through EMRs, including the state-based prescription monitoring program (nj.gov/lps/ca2/pmp/).
- Enforce a Controlled Substance Agreement across the delivery system for patients taking opioids for chronic conditions. Any provider within the system can see whether a patient has an existing agreement, which outlines expectations, roles, and responsibilities, including circumstances under which a prescription will not be given. The agreement is shared with the emergency department, as well.
- Develop registries that enable practices to receive a monthly report showing a list of their patients taking opioids, benzodiazepines, and those taking both.

New Jersey: Multispecialty practice  
Focus areas: EMR

- EMRs standard prescription sentences may include a default opioid prescription of 30 days. This group decided to bring the default prescription into the CDC recommended day and dosage ranges so that in order to prescribe a longer supply, the prescriber is required to make a manual change.

North Carolina: Integrated delivery system  
Focus area: Medication-assisted therapy

- Incentivize PCPs to obtain the training and certification needed to provide medication-assisted therapy.
- PCPs may consider collaborating with specialists such as psychiatrists for the more time intensive induction phase of medication-assisted therapy for those patients with an opioid addiction. Once the patient is on a stable dose, the PCP could accept that patient into his or her practice for ongoing maintenance.
To account for the risk of relapse, the PCP should proactively establish a relationship with a local behavioral health provider to serve as a referral resource if substance use counseling is indicated.

Pennsylvania: Specialty behavioral provider
Focus area: Patient communication
- Review opportunities to speak with patients about opioids and look for moments to engage. For example, when scheduling an annual exam ask the patient if there are unused opioids in his or her medicine cabinet – if there are, ask that the patient bring them to the appointment for safe disposal.

Texas: Integrated delivery network
Focus areas: Best practices
- Establish recommendations for initiating an opioid prescription best practices guideline for both acute and chronic pain management.
- Develop practice-standard resources to assist in discussions between prescribers and patients on the benefits, risks, and alternatives of opioid management.
- Adjust EMRs to allow for documentation of discussion of benefits, risks, and alternatives, as well as the plan for opioid use in a standard template.
- Identify web-based continuing medical education regarding non-pharmacologic treatment for pain.

Texas: Integrated delivery network
Focus areas: Best practices, educational forum, pain management agreement
- Form a work group to identify best practices around prescribing of controlled substances and pain management and update policies accordingly.
- Engage a former Drug Enforcement Agency (DEA) agent, or other specialist, to complete unannounced site visits to ensure that controlled substance logs are up to date, and that controlled substances are properly stored and monitored.
- Devote a Saturday to continuing medical education sessions for providers on the topic of proper utilization of controlled substances.
- Institute a controlled substances agreement into the electronic medical record to help providers easily create the document during a patient encounter. This agreement is customized with patient-specific information, then signed and saved in the medical record under a specific document type for ease of access by the care, compliance, and risk teams.

Virginia: Clinically integrated network in Virginia
Focus areas: CDC guidelines, prescribing protocols
- Revise practice-based documents to reflect CDC guidelines including:
  - Pain management guidelines
  - Chronic pain templates
- Enhance opioid prescribing protocols:
  - Check the state prescription drug monitoring program
  - Order drug tests for patients
  - Screen for depression
  - Validate patient improvement on the medication and screen for functional improvement or disability on follow-up visits
- Increase the number of pain management specialists to broaden their geographic availability.