Implementing Safe Opioid Prescribing in Kaiser Permanente Northern California

San Francisco Health Service System Board of Directors
November 9, 2017

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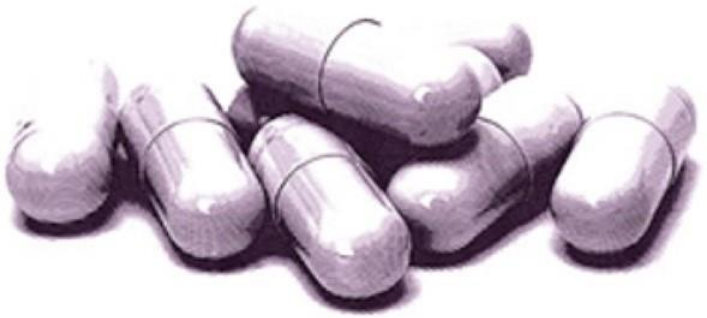
Impact of Opioids in the US

More than **40** PEOPLE die every day from overdoses involving **prescription opioids**.

Each day, more than **1,000** PEOPLE are treated in **emergency departments** for not using prescription opioids as directed.



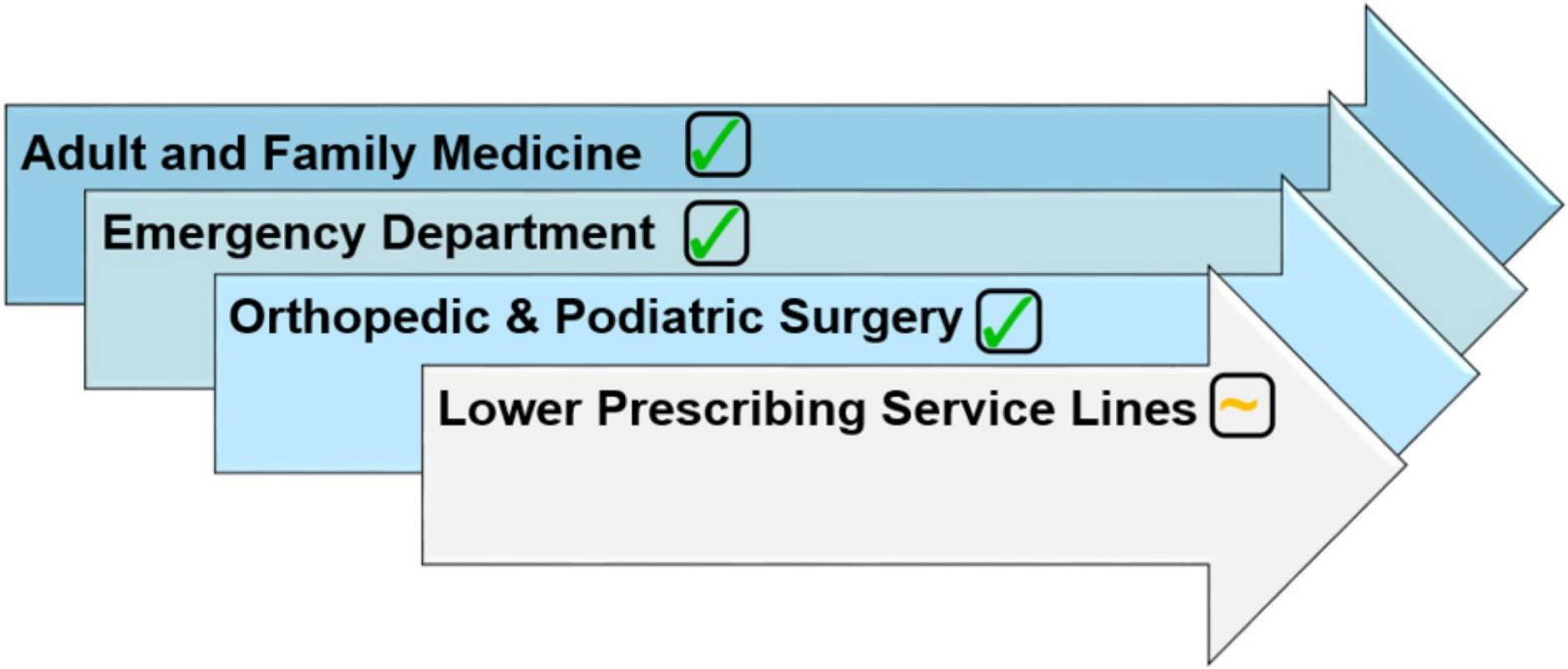
*Between 1999-2015, **183,000 deaths** from Rx opioid-related overdoses*

The Permanente Medical Group (TPMG) Opioid Initiative Goal

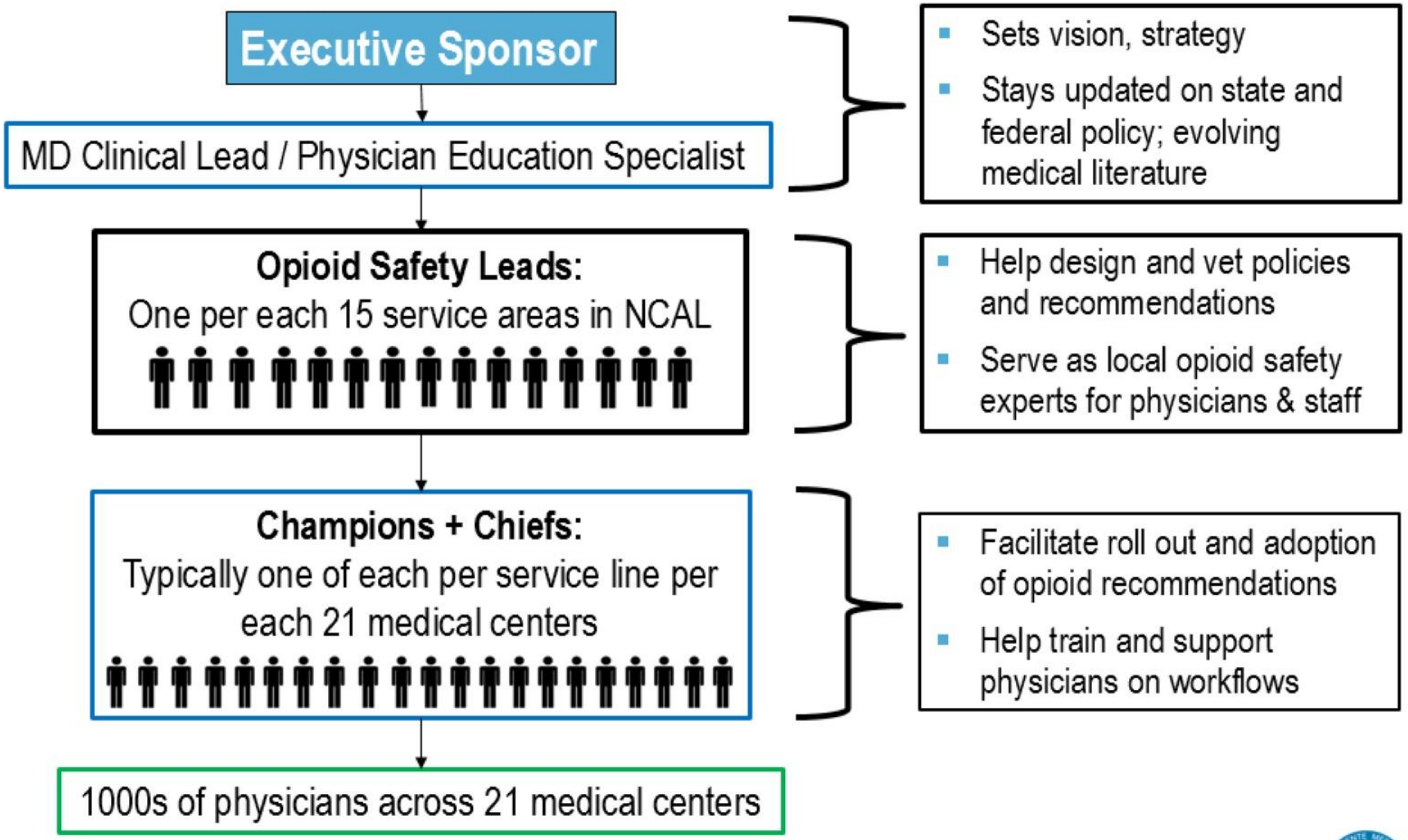
Ensure that we provide safe, appropriate care to our patients across the region and that we give physicians the tools and support needed for consistent opioid prescribing, monitoring and documentation.

TPMG Opioid Safety Initiative

- Staggered roll out to create culture of opioid safety throughout the organization



Opioid Safety Initiative – Leadership Structures



Our Four-Pronged Approach to Opioid Safety

Physician Education + Support

- ❑ **Detailed workflows** for acute and chronic pain
- ❑ **EMR tools and decision support** technology to reinforce workflows and alert physicians to higher risk scenarios
- ❑ **Robust trainings** (in person and online) on scope of opioid epidemic, recommended workflows, patient communication strategies, and tapering approaches
- ❑ **Effective collaboration with Chronic Pain experts** (physicians, pharmacists, physical therapists, case managers, etc.)
- ❑ **Shared decision making tools** for clinician-patient discussions

- ❑ Monthly **prescriber-level reporting** on various opioid safety metrics and prescribing patterns
- ❑ Programs to **effectively manage spine-related pain**
- ❑ Guidance for patients on **concomitant marijuana and opioids**
- ❑ Tools and trainings to **improve communication and collaboration across service lines**
- ❑ Easy access to **state prescription monitoring database**
- ❑ Extensive **partnerships with KP pharmacy**

Patient Education

- **Detailed informed consent** (medication agreement) detailing risk/benefits of chronic opioid therapy and behavioral expectations
- Wide array of **online media and educational material**
- Robust **workshops on self-care** for chronic pain patients
- **Periodic and consistent visits** with physician to discuss pain condition and opioid medication (frequency varies based on physician discretion and state regulations)

Patient Safety

- ❑ **Higher dose patients encouraged to taper** when clinically appropriate
- ❑ **Reduced quantity and frequency of opioid prescriptions** in ED and after surgery
- ❑ **Decreased number of patients** on opioids in addition to benzodiazepines, skeletal-muscle relaxants, and/or Z-drugs

- ❑ **Increased availability of Naloxone** for higher risk patients
- ❑ **Alternatives to opioids offered** whenever possible and clinically appropriate
  - Mindfulness training
  - Tai Chi
  - Acupuncture
  - Group classes on pain management
  - Cognitive behavioral therapy

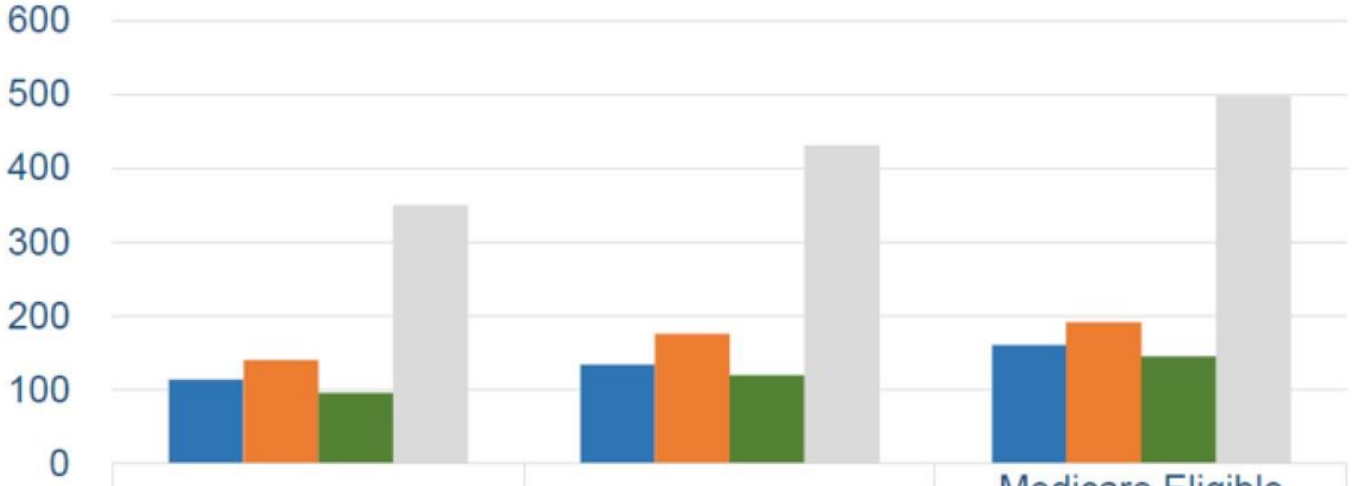
Community Protection

- ❑ **Decreased total quantity of opioids** in the community through reduced prescribing
- ❑ **Increased access to medication take back bins** in our pharmacies
- ❑ **Consistent monitoring of Urine Drug Screen and state prescription monitoring database** prevents diversion
- ❑ **Minimize use of products with higher risk of diversion**
- ❑ **Increased availability of safe opioid dispensing methods** removes barriers to dispose of excess opioid medication
- ❑ **Strategic partnerships with various community initiatives** aiming to improve opioid safety
- ❑ **Reports to monitor unusual prescribing patterns and opioid prescription purchases** prevents diversion
- ❑ **Collaborations with government, academic, and non-profit organizations** to promote best practices for opioid safety (East Bay Safe Rx Coalition, Santa Clara County Opioid Overdose Prevention Project, etc.)

Key measures of success

Service Line	Measure of Success
Total (all service lines)	• 42% reduction in total opioids prescribed since 2013
Primary Care	• 30% reduction in number of patients on high doses (amidst significant membership growth) • >80% increase in patients with med agreement • >45% increase in patients with recent UDS
Emergency Dept	• 44% reduction in encounters resulting in opioid Rx
Orthopedics	• 15% reduction in opioid prescribing in last year

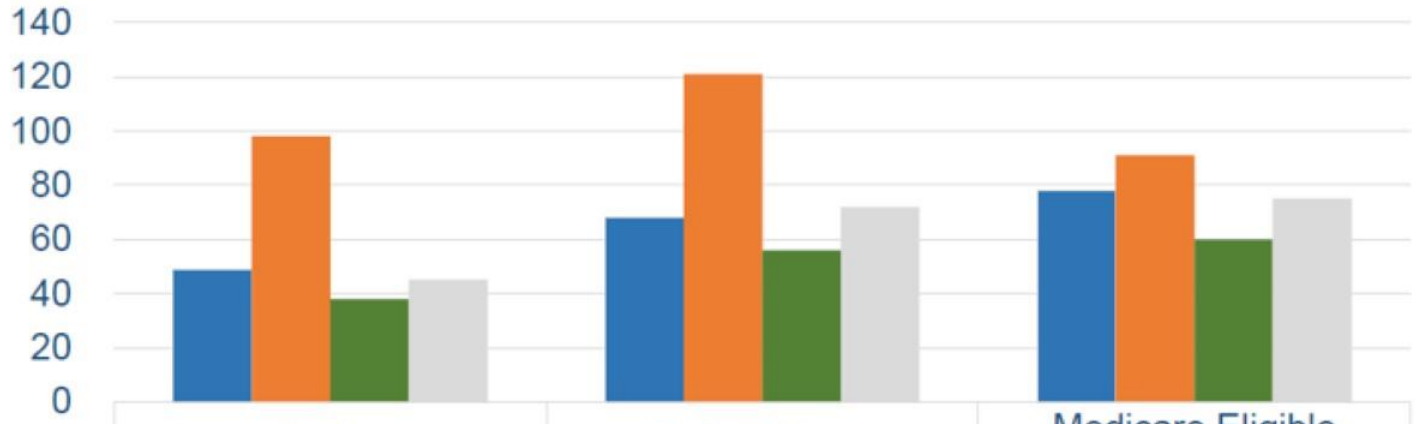
Continuously Enrolled Opioid Recipients per 1000



	2015		
Blue Shield	114	135	161
City Plan	140	176	192
Kaiser	96	120	145
Total(Active, Early Retiree Members in all Plan Groups	350	431	498

- In 2015, City Plan Medicare Eligible Retiree and Early Retiree members accounted for the highest number of recipients per 1000 with an opioid prescription at 192 and 176 recipients per 1000 respectively
- Blue Shield Medicare Eligible Retiree members accounted for the second highest number of recipients per 1000 with an opioid prescription at 161 recipients per 1000
- Kaiser Active members had the lowest number of recipients per 1000 with an opioid prescription at 96 recipients per 1000

Days Supply per Continuously Enrolled Opioid Recipient



	2015		
Blue Shield	49	68	78
City Plan	98	121	91
Kaiser	38	56	60
Total (Active, Early Retiree Members and Medicare Eligible Retirees) in all Plan Groups	45	72	75

- Across Plans, Early Retiree and Medicare Eligible Retiree, have the highest quantity of days supply per opioid recipient which is consistent with national trends
- City Plan Early Retiree members have the highest number of days supply per opioid recipient at 121 days supply

Successful Strategies

- Strong, visible leadership support
- Clarity and consistency of message across physicians & administration
- Interdisciplinary work group to oversee decisions
- Provide coaching, education and support
- Include patient-clinician communication strategies
- Use of physician specific data
- Identify individuals to help colleagues with tough cases
- Collaboration between the medical group and pharmacy

Thank you

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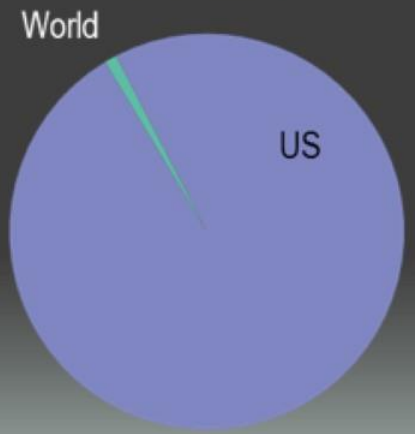
APPENDIX

Source: Institute of Medicine, Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Washington, DC: The National Academies Press, 2011

Americans: 4.6% of World's Population

80% Global Opioid Supply

99% Global Hydrocodone Supply



Manchikanti, L., & Singh, A. (2008). Therapeutic opioids: a ten-year perspective on the complexities and complications of the escalating use, abuse, and nonmedical use of opioids. *Pain physician, 11*(2 Suppl), S63-S88.

Physician Education + Support

Pharmacy Initiatives and Collaborations

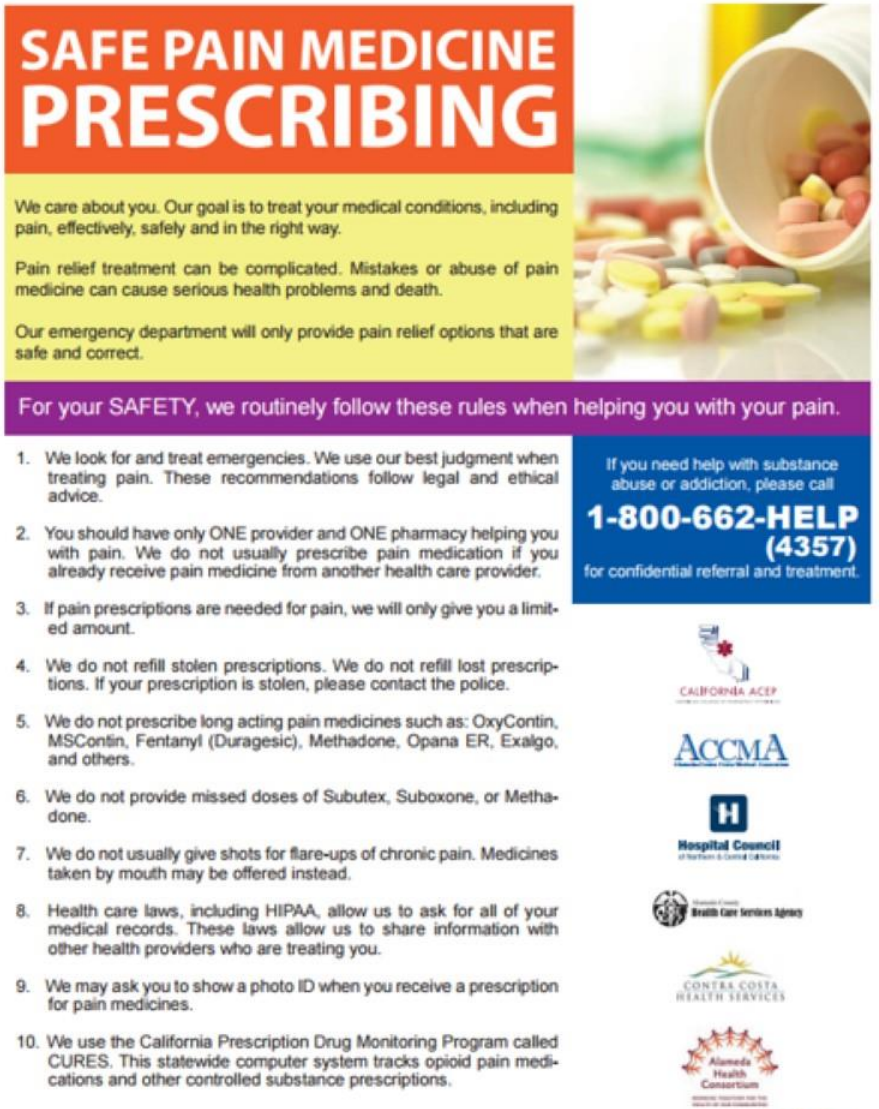
- ❑ **Review all high dose prescriptions** and consult with prescriber when necessary
- ❑ Review all prescriptions for short and long acting opioids **exceeding a pre-determined pill count**
- ❑ Review **any Fentanyl script in Opioid naïve patients**
- ❑ Direct **furnishing of Naloxone** by pharmacists (pilot program)
- ❑ Pharmacy notifications for **early opioid prescription**
- ❑ Drug Use Management initiatives focused on **promoting appropriate and safe opioid utilization**

Participation in Community Initiatives

- TPMG opioid safety leadership has participated in various community initiatives
  - **East Bay Safe Prescribing Coalition** (administered by ACCMA) – a partnership of all 20 East Bay emergency departments to improve opioid safety
  - **Santa Clara County Opioid Overdose Prevention Project**

ACCMA
Alameda-Contra Costa Medical Association

SCCOOPP
Santa Clara County Opioid Overdose Prevention Project



Adult & Family Medicine Opioid Workflows:

Patients with Chronic Non-Cancer Pain

New Start - Acute Pain

If opioids are indicated prescribe:
Short acting opioids

After 2 months:
Do Chronic Opioid Therapy Assessment.

Beware of the 90 day cliff

New Start - Chronic Pain
Chronic Opioid Therapy (COT) Assessment

Chronic Opioid Therapy Assessment:

1. Patient hx, pain hx, physical exam
2. Validated patient self assessment tool (ex: SOAPP, ORT)
3. CURES
4. Assess for alcohol dependence
5. Create Treatment Plan

If benefits outweigh risk:

1. Opioid Medication Agreement
2. Prescribe max 30 day supply

Ongoing Assessment and Management of Chronic Opioid Therapy (COT) - Chronic Pain

1. Physical exam
2. 5A's Assessment
3. CURES
4. Assess for alcohol dependence
5. Urine Drug Screen
6. PHQ-9 or equivalent (PRN)

   For patients who did not have a chronic opioid therapy assessment prior to beginning COT, ensure patient hx, validated self assessment tool, and Opioid Medication Agreement are completed.

7. Revisit treatment plan and modify as needed

Risk / Benefit assessment includes consideration of:

- Contraindications and conditions for which opioids are not appropriate / generally not recommended
- "Red Flags" – e.g. Score associated with risk on validated risk assessment tool, unexpected UDS finding, failure to follow Opioid Medication Agreement, personal history of substance abuse, aberrant opioid fills per CURES, use of any non-opioid controlled substance, patients on ≥100 MME of opioids

ED Opioid Workflows: New Pain or Recurrent Pain

History & Assess Risk

For ALL PATIENTS presenting with non-cancer pain in the Emergency Department

Review for:

1. Chief complaints for which opioids are generally not indicated
2. Current/past opioid prescriptions. *For outside members verify through CURES and Epic Outside Records.*
3. Review for diagnosis in EMR problem list that indicates patient is being actively managed by PCP or pain physician for chronic pain.
4. Check EMR Specialty Notes section for comments.
5. Assess for red flags. If red flags present, Check CURES.

New Pain or Recurrent Pain?

Determine type of complaint:

- **New pain** is different from the patient's usual pain condition.
- **Recurrent pain** is the patient's usual pain experience. This pain has been ongoing for 3 months or more.

Treatment Plan

Determine treatment plan – All Patients

1. Determine if benefits outweigh the risks for prescribing opioids.
2. Consider alternative and adjuvant therapies.
3. Do not replace lost of stolen prescriptions.
4. Educate patient on risks, benefits and limitations of treatment(s).
5. Document rationale for prescribing or not prescribing opioids. If prescribing provide patient with education via after visit summary.

New Pain Complaint – Opioids may be indicated

- **Treatment**– If prescribing opioids, prescribe amount needed until follow-up, generally maximum 20 pills.
- **Referral** – Refer patient to appropriate physician for follow-up of acute pain management, treatment plan reassessment, and refill requests.

Recurrent Pain Complaint – Opioids rarely indicated

- **Treatment**– Avoid IM or IV opioid analgesics. If giving opioids, prescribe usual dosage for a maximum of 3 days OR 10 pills.
- **Referral** – Send chart to physician managing chronic opioid therapy; mention if you did or did not prescribe opioids and why. If there are red flags, route chart to ED Opioid Champion.