It Takes a Village to Curb the Prescription Opioid Epidemic:
Reducing Opioid Over-Prescribing in a Large Integrated Health Care System

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1pm-4:30pm

Intro to Kaiser Permanente

- Founded in 1945, Kaiser Permanente is one of the nation’s largest not-for-profit health plans, serving more than 9.1 million members across 8 regions nationwide
- 38 hospitals
- 630 medical offices
- 18,652 physicians
- 189,302 Employees
- NCQA has identified Kaiser Permanente Southern California as #2 “Best Value” private health plan in California (KP NCAL is #1)
- 4.2 million members
- 13 service areas
- Over 7,000 physicians
- 135 medical office buildings
- 14 Kaiser Foundation Hospitals
- Over 130 licensed pharmacies
How are we going to tackle this overwhelming challenge, manage chronic pain in our patients and make a difference?

We have to do something!

“Tackling the Opioid Epidemic: An Integrated, Population Care Management Approach”

Framework for Safe & Appropriate Opioid Prescribing

1. Check & Acknowledge the problem with data
We too had an opioid prescribing problem - DATA

First Clue: OxyContin LA (oxycodone) was our most prescribed, non-formulary medication by cost!!

*Source: Kaiser Permanente SCAL Utilization Data - Jan 2010, Drug Utilization Management
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More DATA

2nd Clue: Hydrocodone/APAP was our #2 most prescribed medication by Volume (PMPMk – Jan 2010)

*Source: Kaiser Permanente SCAL Utilization Data - Jan 2010, Drug Utilization Management
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Become Part of the Solution and Not Part of the Problem of Opioid Over-Prescribing in the U.S.

Organize TEAM

- Local Medical Center Review Teams
- Multi-Disciplinary Task Force
- KP SCAL SCPMG + Pharmacy Executive Team
- Info Systems Workgroup
- Pharmacy Subcommittee
- Internal Departmental Specialty Support Group
- Project management
- Data and analytic support

- Physicians: Primary Care, Pain Mgmt, Addiction, Physical Med, Psych, Neuro, Oncology, Hospital
- Pharmacy: operations, drug education, drug utilization, QM, clinical/pain
- IT
- P&T
- Education- Clinician and patient
- Member Services
- Data & Analysis
- Compliance
- Medical Group Administration
- Project Mgmt
“Tackling the Opioid Epidemic: An Integrated, Population Care Management Approach”

Framework for Safe & Appropriate Opioid Prescribing

1. Acknowledge the problem with data
2. Leadership
3. Build collaboration & TEAM
4. Educational plan
5. Safe prescribing guidelines into P&Ps, formulary
6. Decision-support – leverage EMR, protocols, advice
7. Reliable data & Reporting
8. Peer support and peer pressure
9. Pharmacy/ist engagement – “corresponding responsibility”
10. Inter-specialty support agreements
11. Care Delivery Design
12. Pt/Consumer Education
13. Community Collaboration

Core Set of Specific Initiatives and Actions

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Interdepartmental Specialty Support Agreement

Kaiser Permanente

Opioids Interdepartmental Agreement:
Specialty Support for Primary Care

Goal: Effective pain management incorporating safe and medically appropriate prescribing of opioids for our members, promoted by collegial and supportive relationships among SCPMG clinicians in primary and specialty care.

I.A. Working Principles: SCPMG physicians hereby agree to:

✓ Put the patient's needs first. Above all keep the patient safe.
✓ Never say no to helping an SCPMG colleague in need
✓ Be responsive to phone calls and advice requests from colleagues
✓ Accept referrals, even for one-time consults for advice and direction
✓ Support the primary patient management role of PCP, including transfer of patients back to the PCP, as appropriate
✓ Foster shared ownership of patient care among specialists
✓ Participate in and respond to local multi-disciplinary pain management teams

Important Pain Medicine Information

Your safety is always our priority, and we are committed to helping you achieve pain relief with high-quality care in the Emergency Department. Pain management requires a shared responsibility between you and your healthcare providers. Mistakes or abuse in the use of pain medication can cause serious health problems and even death. Please know that the following practices will be followed:

• We use our best judgment when treating pain.
• You should only have ONE provider and ONE pharmacy helping you with pain. In most situations, we will not prescribe pain medication if you already receive chronic pain medication from other health care providers.
• If pain prescriptions are needed for pain, we will only give you the proper amounts.
• Stolen or lost opioid narcotic pain prescriptions will not be refilled. If your prescription is stolen, please contact the police.
• As a rule, our emergency and urgent care

SAFE PAIN MEDICINE PRESCRIBING
IN URGENT CARE CENTERS

We care about you. Our goal is to treat your medical conditions, including pain, effectively, safely, and in the right way. Pain relief treatment can be complicated. Misuse or abuse of pain medicines can cause serious health problems and death. Our Urgent Care will only prescribe pain relief options that are safe and correct.

For your SAFETY, we follow these rules when helping you with your pain:

1. We use our best judgment when treating pain. These recommendations follow legal and ethical advice.
2. You should only have one provider and one pharmacy helping you with pain. We do not usually prescribe pain medication if you already receive pain medicine from another health care provider.
3. If pain prescriptions are needed for pain, we will only give you a limited amount.
4. We do not refill stolen prescriptions. If your prescription is stolen, please contact the police.
5. We do not prescribe long-acting pain medications such as OxyContin, MSContin, Fentanyl (Duragesic), Methadone, Opana ER, and others.
6. We do not provide unused doses of Subutex, Suboxone, or combinations.
7. We do not usually give shots for follow-ups of chronic pain. Medicines taken by mouth may be offered instead.
8. Health care laws, including HIPAA, allow us to ask for all of your medical records. These laws allow us to share information with other health providers who are treating you.
9. We may ask you to show a photo ID when you receive a prescription for pain medication.
10. We use the California Prescriber Drug Monitoring Program called CURARE. This statewide computer system tracks opioid pain medications and other controlled substance prescriptions.
KP SCAL Results - Improvements in Opioid Utilization: Since January, 2010

- **85% reduction** -- OxyContin (oxycodeone LA) prescribing
- **66% reduction** -- Opana ER (hydromorphone) prescribing
- **98% reduction** -- opioid/acetaminophen combination prescriptions with > 200 tabs (no Rxs filled in 2016 > 200)
- **95% reduction** -- brand opioid prescribing when a generic is available (Brand had greater street value)

Data Source: Kaiser Permanente SCAL Drug Use Management

KP SCAL Results - Improvements in Opioid Utilization: Since January, 2010

- **31% reduction** - patients on > 120 MED/day of opioids
- **17% reduction** - patients on > 100 MEDs/day of opioids (2015-2016)
- **84% reduction** in "Trinity" prescribing (opioid + benzodiazepine + carisoprodol)

Data Source: Kaiser Permanente SCAL Drug Use Management
### Spread Across All of Kaiser Permanente (& Community)

#### Outpatient Setting

<table>
<thead>
<tr>
<th>OP Setting</th>
<th>HI</th>
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1. Limit to 30-30 (30 day supply) no refills under 30 days for OxyContin, OxyNoyce, and all Schedule II Opioids.
2. Limit any prescription to 200 pills for all Opioid combinations.
3. Require an office visit at least every 6 months for reevaluation and for any refill.
4. Recommend that prescribing physician, when responding to requests for early refills due to "stolen" prescriptions (red flag, policy report, conversation).
5. Control prescribing of Suboxone, Subux, or to Narcotics (Pain Management, Addiction, CPT codes).
6. Require the prescriber to answer 3 key questions: insurance, location, severity.
7. Limit new starts of Opioids to 30 days (Pain Management, Oncology, Hospice).
8. Avoid Brand opioid prescribing when a Generics available to include a role for Pharmacy in the appropriateness of a Brand opioid product and/or acting according they have concerns regarding the potential for abuse of the Brand product.
9. Set the default in Prescriptions for the prescribing of 30 day supply of Opioids to 30 pills.
10. Limit 30 day supply of all Schedule II Opioids.

### CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

**Recommendations and Reports / Vol.65 / No.1**

March 18, 2016

**WHAT'S NEW**

- **2016**
- **CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016**
Tackling the Opioid Epidemic

WHAT’S YOUR GAMEPLAN?

SCPMG Opioid Tapering Guide for Patients With Chronic Pain

General Recommendations:
1. The patient who is being treated for chronic pain with opioids needs to be evaluated for opioid use disorder using screening tools such as the CAGE and AUDIT-C.
2. The tapering plan should be individualized for each patient.
3. The taper should be gradual and monitored by a healthcare provider.
4. If a patient reports withdrawal symptoms or has severe opioid use disorder, they should be referred for further evaluation and treatment.

Tapering Steps:
1. Decrease the daily dose by 10% every 2 weeks.
2. If the patient experiences withdrawal symptoms, increase the dose by 10% or discontinue the tapering plan.
3. If the patient does not experience withdrawal symptoms, continue the tapering plan.

Naloxone for opioid safety

Injection-Assisted Treatment

The Opioid Addiction

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Contact Information

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Appendix
### Leadership and Accountability

**Early Steps**
- Identified Regional Sponsors in Med Group and Pharmacy
- *Call to Action*
- Developed relationships with the Chiefs, Medical Directors, Pharmacy leaders
- Engaged experts: Pain Management and Addiction Medicine specialists
- Involved quality leaders in addressing aberrant prescribing

**Later Strategies**
- Inter-departmental specialty support agreement created with Primary Care, Pain Management, PM&R, Addiction Medicine, and Psychiatry
- Engaged Membership Services to address patient questions, complaints, grievances

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### Data and Analysis (＆Reporting)

**Early Steps**
- High dose lists
- Quarterly scorecard
- High patient/prescriber utilizer reports
- Facility and individual action plans
- High risk of diversion lists

**Later Strategies**
- Parenteral prescribing reports
- Pharmacy processes
- Lack of MD follow-up reports
- Changed metrics to track ≥120 mg (2013) MED/day to ≥100 (2015) mg MED/day

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**Education**

**Early Steps**
- 1-on-1 academic detailing
- Frequent communications via emails, newsletters, word of mouth
- Educated 2,500+ SCPMG prescribers on current evidence-based pain assessment and safe opioid prescribing practices with an in-person course (UCSD PACE) and online CME offerings

**Later Strategies**
- Educated all outpatient pharmacists on the appropriate treatment of chronic pain
- CURES registration
- Education of Member Services
- Required Education for every new SCPMG clinician

**Pharmacy & Formulary Management**

**Early Steps**
- Pharmacy Subcommittee
- Restricted new Prescribing of OxyContin & Opana to Pain Management, Oncology, and Hospice
- “30:30” Refill Policy (limit to 30 day supply; no refills in under 30 days) for OxyContin and Opana
- Advocated for the use of generics when available
- Involved ambulatory care pharmacists (case mgmt.) and DEC’s (academic detailing)

**Later Strategies**
- KP Pharmacy escalation calls to prescribers if concerns about excessive dosing, based on **high pill count** (>200 pills/Rx) and **high dose** (>120mg MED/day)
- Learned to ID and avoid the so-called “Trinity” combinations = opioid analgesic + benzodiazepine + Soma
- “30:30” Refill Policy for all Schedule II Opioid Medications
- PDMP (CURES) for Pharmacists
### Decision Support (EMR: KP HealthConnect/Epic)

<table>
<thead>
<tr>
<th>Early Steps</th>
<th>Later Strategies</th>
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<tbody>
<tr>
<td>• <strong>Alerts</strong>: Alternative Medication, Safety, Best Practice</td>
<td>• EMR interface to PDMP</td>
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<tr>
<td>• Order Entry Questionnaires</td>
<td>• Opioid MED calculator embedded in EMR (MEDs are key)</td>
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<tr>
<td>• Protocols</td>
<td>• On-line DR.ADVICE</td>
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<tr>
<td>• Prescribing guidelines</td>
<td>• Smart Dot Phrases</td>
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<tr>
<td>• Treatment Agreement</td>
<td>• Smart Sets</td>
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<tr>
<td>• Tools for consistent documentation and ordering (v-code “Monitoring Opioid Therapy”)</td>
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<td>• HealthConnect log-in screen messages</td>
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### Care Delivery Design

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<th>Early Steps</th>
<th>Later Strategies</th>
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<tr>
<td>• Evaluate the current structure (e.g. addiction and pain medicine)</td>
<td>• Assure timely follow up for chronic opioid patients</td>
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<tr>
<td>• Opioid Treatment Agreement</td>
<td><strong>ED and Urgent Care:</strong></td>
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<tr>
<td>• Urine Drug Testing</td>
<td>• Avoid injectable opioids for exacerbations of chronic, non-cancer, non-hospice pain in ED and Urgent Care, for patients already on chronic opioids</td>
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<tr>
<td>• PDMP (CURES)</td>
<td>• Limit discharge Rx quantity</td>
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<tr>
<td>• Support for primary care prescribers</td>
<td>• No refills or replacements for lost or stolen meds</td>
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<tr>
<td>• Referral/consultation system</td>
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<tr>
<td>• Leveraged the “Patient Safety Net” to address patients on high doses of APAP (acetaminophen &gt; 4gms/day)</td>
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<td>• Acted on CMS Requirements</td>
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Community Outreach & Collaboration

Strategies

- Los Angeles County Coalition to support consistent pain treatment best practices in all Emergency Departments, Urgent Care Clinics, and Medical & Dental practice in LA County – “SafeMedLA”
- California Health Care Foundation
- Institute for Healthcare Improvement
- CDC