Ensuring Safe & Appropriate Opioid Use in Kaiser Permanente Patients & the Community

Joel D. Hyatt, MD
Assistant Regional Medical Director, Quality

Steve Steinberg, MD
Regional Chief, Family Medicine

Southern California Permanente Medical Group
Kaiser Permanente Medical Care Program

October 23, 2013
What We Will Talk About Today

1. Problem discovery
2. Epidemic of prescription opioids in the United States
3. Evidence-based medicine
4. Intervention strategies and tactics
5. Results to date
6. Lessons learned
7. Call to action: Community-wide opportunity
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
- 37 hospitals
- 611 medical offices
- 17,157 physicians
- 175,668 employees

- NCQA has identified Kaiser Permanente Southern California as #2 “Best Value” private health plan in California (KP NCAL is #1)

KP Southern California

- 3.6 million members
- 13 service areas
- 130 medical office buildings
- Over 7,000 physicians
- 14 Kaiser Foundation hospitals
- Over 100 pharmacies
Initial Discovery (2009)

It all started by accident –
We discovered that Oxycontin LA (oxycodone) was our most prescribed, non-formulary medication by cost!
Initial Discovery: Peeling the Onion

We found:

1. High prescribing patterns of OxyContin LA, Opana, and Actiq
2. Patients with multiple prescribers and/or frequent refills
   - Overlapping therapeutics: e.g., Norco one week, Percocet the next
   - Cascading scripts: Rx for 3-month supply and patient returns in ≤1 month
3. Risky cumulative doses of acetaminophen (APAP) with opioids
4. Brand opioids when generic was available (diversion risk?)
5. Distance traveled to see prescriber: 40-60 miles (drug-seeking?)
6. Increasing doses by ~30% every 6 months, leading to VERY high doses
7. 80-20 rule: Minority of prescribers with high-dose prescribing
8. Opioids for conditions not indicated (i.e., fibromyalgia)
In 2008, there were 14,800 prescription Painkiller-related deaths in the United States. (CDC)
Drug deaths now outnumber traffic fatalities in U.S., data show

Fueling the surge are prescription pain and anxiety drugs that are potent, highly addictive and especially dangerous when combined with one another or with other drugs or alcohol.

September 17, 2011 | By Lisa Girion, Scott Glover and Doug Smith, Los Angeles Times

Propelled by an increase in prescription narcotic overdoses, drug deaths now outnumber traffic fatalities in the United States, a Times analysis of government data has found.

Drugs exceeded motor vehicle accidents as a cause of death in 2009, killing at least 37,485 people nationwide, according to preliminary data from the U.S. Centers for Disease Control and Prevention.

While most major causes of preventable death are declining, drugs are an exception. The death toll has doubled in the last decade, now claiming a life every 14 minutes. By contrast, traffic accidents have been dropping for decades because of huge investments in auto safety.

Public health experts have used the comparison to draw attention to the nation’s growing prescription drug problem, which they characterize as an epidemic. This is the first time that drugs have accounted for more fatalities than traffic accidents since the government started tracking drug-induced deaths in 1979.

Fueling the surge in deaths are prescription pain and anxiety drugs that are potent, highly addictive and especially dangerous when combined with one another or with other drugs or alcohol. Among the most commonly abused are OxyContin, Vicodin, Xanax and Soma. One relative newcomer to the scene is Fentanyl, a painkiller that comes in the form of patches and lollipops and is 100 times more powerful than morphine.

Such drugs now cause more deaths than heroin and cocaine combined.
More deaths from prescription opioids than heroin, cocaine, and benzo’s combined.
Rates of Opioid Overdose Deaths, Sales, and Treatment Admissions, United States, 1999–2010

Americans consume 80% of the world supply of prescription opioids and 99% of the world’s hydrocodone!

1. CDC. MMWR 2011 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm60e1101a1.htm?s_cid=mm60e1101a1_w Updated with 2009 mortality and 2010 treatment admission data.
Evidence-based Chronic Pain Management
High-dose opioids may contribute to pain sensitization via opioid induced hyperalgesia (OIH), decreasing patient pain threshold, and potentially masking resolution of a pre-existing pain condition.
Opioids are powerful drugs and should be reserved for serious pain.

90% of pain complaints do not meet these criteria.

Axial low back pain without a pathoanatomic diagnosis

Fibromyalgia

Headache

90 days is a key point
Beware of the “90 day cliff”

- 90 days is often used in definitions of chronic pain
- Studies show that after 90 days of continuous use, opioid treatment is more likely to become life-long
- Studies show that patients who continue opioids >90 days tend to be high-risk patients

High Opioid Dose and Overdose Risk

Doses > 100mg MED/day are a RED FLAG!

* Overdose defined as death, hospitalization, unconsciousness, or respiratory failure.

## Mayo Clinic Experience:
### Pain Rehabilitation Center Treatment Outcomes

### Medication Use by Patients

<table>
<thead>
<tr>
<th>Medications</th>
<th>At Admission</th>
<th>At Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily opioid (prescription) pain medications</td>
<td>57%</td>
<td>7%</td>
</tr>
<tr>
<td>Non-steroidal anti-inflammatory drugs (e.g., Ibubrofen)</td>
<td>46%</td>
<td>23%</td>
</tr>
<tr>
<td>Muscle relaxants</td>
<td>17%</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Pain Severity**

Although the program focuses on functioning and quality of life, 73 percent of patients who completed the program reported a reduction in pain severity at dismissal.

http://www.mayoclinic.org/pain-rehabilitation-center-rst/ (10/16/2013)

Greater control over pain: 84%

**Decrease pain severity despite discontinuing pain meds:** 70%

Increase aerobic activity 93%

Decrease depression Rx’s 80%
Intervention Strategies & Tactics
Kaiser Permanente (and CDC) Goal

Reduce overuse, abuse, and overdosing of opioids (and other controlled prescription drugs) while ensuring patients with pain are treated safely and effectively.
Early Approaches to the Problem

1. Restricted new prescribing of OxyContin and Opana to pain management, oncology, and hospice
2. 30:30 refill policy (limit to 30-day supply; no refills in under 30 days)
3. Encouraged the use of generics when available (brand meds have high street value)
4. Education: 1-on-1 academic detailing; frequent communications
5. Decision-support in EMR: Alternative Medication Alerts and Order Entry Questionnaires (hard stop). Includes prescribing guidelines
6. Pharmacy calls to prescribers triggered by excessive dosing of certain medications
Early Approaches to the Problem
(continued)

7. High patient/prescriber utilizer reports, and facility and individual action plans
8. Medical Center specific interventions
9. Launched Regional and Medical Center Controlled Substances Teams
10. Intervene with patients on >4000mg/day cumulative acetaminophen
11. New “high risk of diversion” reports
12. Activated Pain Management and Addiction Medicine specialists
13. Opioid agreement, urine testing
One example of many and varied Communications

**OxyContin**

A High Risk Medication for Abuse and Diversion

OxyContin is a medication with a very high risk of drug abuse and for diversion and/or "street resale." It is the one of the most widely abused prescription drugs in our schools, and teens who take this medication often end up with opiate addictions. It's also not uncommon for OxyContin abusers to escalate their drug abuse to heroin.

At Kaiser Permanente Southern California, we prescribed approximately 64 million milligrams of OxyContin over the past 12 months. Even if a small percent of this amount ends up being diverted for resale, it poses a significant threat to our communities.

Our organization stands for not just health, but for the well-being of our communities. As a result, we are now tracking all prescriptions for OxyContin regionally. By decreasing the orders for OxyContin, we can help abate its potential risk of drug abuse.

If you already have patients on OxyContin, we strongly encourage you to change their prescription to one of our appropriate formulary medications.

The SCPMG Regional Pain Management Committee, Regional Drug Utilization Action Team (DUAT) and Regional P&T Committee endorse prescribing Morphine Sulfate ER first when a long-acting opioid analgesic is indicated. (See the 4-23-10 edition of Rx Update.)

---

**Therapeutics News**

**New Restrictions for Prescribing Provigil or Nuvigil**
Beginning July 7, 2010, all prescriptions written for a new start of Provigil or Nuvigil that are not written by (or in consultation with) a neurologist will not be filled. [Read more...]

**When Patients Bring Prescriptions from Outside KP**
What does an SCPMG physician do when a patient walks in with a prescription from an outside provider? It's an important answer to know—[read it here].

**Rx Resources**

**Rx UPDATE**
Simvastatin & Pravastatin... Our Statins of Choice

**DRUG BULLETIN**
KP Wins Pfizer Lawsuit / CMI Updates / 2010 Pharmacy Benefit Changes

**Drug Recalls >>**

**Latest Shortages >>**

**OXYCODONE 15 MG ORAL 12HR SR TAB**

* This is a Non-Formulary and non-preferred chronic pain medication with HIGH ADDICTION POTENTIAL

* NEW START prescribing is RESTRICTED to the following specialties: (1) Hospice (2) Oncology and (3) Pain Specialists

* OxyCONTIN is limited to a 30-day supply within a 30-day period

* WARNING: >240mg/day is considered to be an UNUSUALLY HIGH dose. Pharmacy staff will contact the prescriber to verify the dosing and need for continued high-dose therapy

Please consider use of lower doses or preferred Formulary agents when clinically appropriate

* Morphine SR and fentaNYL patches are the preferred Formulary long-acting opioids for chronic pain

* Non-Formulary (NF) oxyMORphone ER (OPANA ER) may be considered if morphine SR or fentaNYL patches are not tolerated

* FentaNYL patches should not be used in opiate-naive patients

* APPROXIMATE equianalgesic oral doses:

  30 mg morphine = 20 mg oxyCODONE = 10 mg oxyMORphone

  fentaNYL 25 mcg/h patch = morphine SR 60 mg Q12H

**Alternative Selection**

<table>
<thead>
<tr>
<th>Alternative</th>
<th>Sig</th>
<th>Disp</th>
<th>Refill</th>
<th>End Date</th>
<th>Class</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORPHINE 15 MG ORAL SR TAB</td>
<td>1 TAB PO Q12H</td>
<td>60</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MORPHINE 30 MG ORAL SR TAB</td>
<td>1 TAB PO Q12H</td>
<td>60</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MORPHINE 60 MG ORAL SR TAB</td>
<td>1 TAB PO Q12H</td>
<td>60</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MORPHINE 100 MG ORAL SR TAB</td>
<td>1 TAB PO Q12H</td>
<td>60</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FENTANYL 12 MCG/HR TD 72HR PATCH</td>
<td>APPLY 1 PATCH TO SKIN Q72H. REMOVE...</td>
<td>5</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FENTANYL 25 MCG/HR TD 72HR PATCH</td>
<td>APPLY 1 PATCH TO SKIN Q72H. REMOVE...</td>
<td>5</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FENTANYL 50 MCG/HR TD 72HR PATCH</td>
<td>APPLY 1 PATCH TO SKIN Q72H. REMOVE...</td>
<td>5</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FENTANYL 75 MCG/HR TD 72HR PATCH</td>
<td>APPLY 1 PATCH TO SKIN Q72H. REMOVE...</td>
<td>5</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FENTANYL 100 MCG/HR TD 72HR PATCH</td>
<td>APPLY 1 PATCH TO SKIN Q72H. REMOVE...</td>
<td>5</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OXYMORPHONE 5 MG ORAL 12HR SR TAB</td>
<td>1 TAB PO Q12H ON AN EMPTY STOMACH...</td>
<td>60</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OXYMORPHONE 10 MG ORAL 12HR SR TAB</td>
<td>1 TAB PO Q12H ON AN EMPTY STOMACH...</td>
<td>60</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OXYMORPHONE 20 MG ORAL 12HR SR TAB</td>
<td>1 TAB PO Q12H ON AN EMPTY STOMACH...</td>
<td>60</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OXYMORPHONE 40 MG ORAL 12HR SR TAB</td>
<td>1 TAB PO Q12H ON AN EMPTY STOMACH...</td>
<td>60</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Supporting Evidence-Based Drug Use

EMR Decision-Support: Order Entry Questionnaires (2011)

Del Kphc, Kphc

Place orders (Enc Date: 11/9/2011) - Wt: (Not entered for this visit) Ht: (Not entered for this visit)

Mark long-term: OXYCODONE HCL

Questions:
1. NEW START prescribing of Non-Formulary OxyCODONE (OXYCONTIN) is RESTRICTED to: 1) Hospice 2) Oncology and 3) Pain Specialists. If you do not belong to one of these specialties, have you consulted a physician in one of these groups?
2. Please document the name of the SCPMG specialist consulted.
3. Are you aware that Oxycodeine SR has VERY high risk for addiction, abuse and diversion?
4. What other preferred long acting narcotics has this patient tried?
5. Is the prescribed dose greater than 240mg/day? WARNING: OxyContin dose >240mg/day is considered to be an UNUSUALLY HIGH dose.

Taking:

Accept Cancel Remove

Back to top

F7- Prev Order F8- Next Order
Supporting Evidence-Based Drug Use

Recent Strategies & Tactics (2013+)

1. Educated over 2,200 prescribers on current evidence-based pain assessment and safe opioid prescribing practices (UCSD PACE Program) + CURES registration
2. ID and avoid the “Trinity” Rx Combos = opioid analgesic + benzodiazepine + Soma
3. EMR interface to CURES + opioid MED* calculator embedded in EMR (MEDs are key)
4. Schedule office visits for high-dose chronic opioid patients without an office visit in > 6 months (per Medical Board of California guidelines)
5. KP Pharmacy phone calls to prescribers for concerns about excessive dosing, based on high pill count (>200 pills/Rx) and high dose (>120mg MED/day)
6. Inter-departmental agreements with Pain Management, Addiction Medicine, Psychiatry
7. Adopting clinical practice recommendations for ED and Urgent Care (from AAEM)
   • Avoid opioid injectables to COT* patients for exacerbations of chronic, non-cancer, non-hospice pain in ED and Urgent Care
   • Limit discharge prescription quantity; no refills; no replacements for lost or stolen meds, etc.
   • Building a community coalition for spread of opioids safe prescribing best practices

* MED = morphine equivalent dose ; COT = chronic opioid treatment
San Diego County Safe Pain Prescribing Handout

- All the EDs in San Diego and Imperial Counties, including Kaiser Permanente in San Diego, have agreed to participate in this program.
- Handed to all patients at ED discharge.
- Follows American Academy of Emergency Medicine (AAEM) recommendations.

**SAFE PAIN MEDICINE PRESCRIBING IN EMERGENCY DEPARTMENTS**

We care about you. We are committed to treating you safely and in the right way.

Pain relief treatment can be complicated. Mistakes or abuse of pain medicine can cause serious health problems and death.

Our emergency department will only provide pain relief options that are safe and correct.

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

1. We look for and treat emergencies. We use our best judgment when treating pain. These recommendations follow legal and ethical advice.

2. You should have only 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 can only give you a small amount.

4. We do not refill stolen prescriptions. We do not refill lost prescriptions. If your prescription is stolen, please contact the police.

5. We do not prescribe long acting pain medicines: OxyCon-tin, MSContin, Dilaudid, Fentanyl (Duragesic), Methadone, Opana ER, Exalgo, and others.

6. We do not provide missing doses of Subutex, Suboxone, or Methadone.

7. We do not usually give shots for flare-ups of chronic pain. Medicines taken by mouth may be offered instead.

8. Health care laws, including HIPAA, allow us to ask for 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 medicines.

10. We use the California Prescription Drug Monitoring Program called CURES. This statewide computer system tracks narcotic and other controlled substance prescriptions.

Adopting across all of KP SCal by 1/1/2014

Working to spread this to other counties in California.
Results to Date
Progress in Reducing High-Risk Opioids

OxyContin Use Trending Down Since 2010 (- 80%)

We have reduced the amount of Oxycontin in the community by over 100 million milligrams per year, without reducing effective pain management.
Progress in Reducing High-Dose Opioids Risk in SCPMG (> 120 mg MED/day)

21% fewer members on high-dose opioids in Q2 2013 than in Q2 2012

Region KP SCAL Opioid High Utilizer MRN Counts
Q2 2012 to Q2 2013
(≥120 mg MED/day)

<table>
<thead>
<tr>
<th></th>
<th>Q2 2012</th>
<th>Q3 2012</th>
<th>Q4 2012</th>
<th>Q1 2013</th>
<th>Q2 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>6,487</td>
<td>5,984</td>
<td>5,827</td>
<td>5,242</td>
<td>5,110</td>
</tr>
</tbody>
</table>

MRN High Utilizers Per 1,000 18+ Members / Month
Q2 2012 - Q2 2013

<table>
<thead>
<tr>
<th></th>
<th>2012-Q2</th>
<th>2012-Q3</th>
<th>2012-Q4</th>
<th>2013-Q1</th>
<th>2013-Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>REG</td>
<td>0.80</td>
<td>0.73</td>
<td>0.71</td>
<td>0.63</td>
<td>0.61</td>
</tr>
</tbody>
</table>

23% lower PMPM from Q2 2012 to Q2 2013

MED = Morphine-Equivalent Dose

* Inclusion criteria for MRN High Utilizer status shown above based on assessment of a rolling 3-month opioid Rx refill history
95% Reduction in Brand Opioid Rxs When Generic Available*

Brand opioids fetch a higher street value, which reduces diversion and abuse in the community

- Brand vs. generic Hydrocodone, oxycodone, and codeine with acetaminophen combination meds
What We’ve Learned

- **Leadership**
- Change management
- Prescribers need support: evidence, re-education, decisionmaking, feedback, re-enforcement
- Multi-stakeholder collaboration
- Data
- Communication X 3
Discussion