# How Plans Can Support Safe Prescribing

May 20, 2015

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California HealthCare Foundation

California Improvement Network
Better Ideas for Care Delivery

# Today's Speakers

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# Opiates- 2 case studies and learnings

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# Objectives

- Review large clinic system approach
  - Learnings
- Review plan system approach
  - Learnings

# Public Health Epidemic

- Overall rate of poisoning grew over 360%
- Deaths from prescription opiates
  - Patients with prescriptions
  - People who obtain ”community pills”
- “Rx written to death ratio” so high – all prescribers had at least one death related to opiates
- Fastest growing in 15-17yo!

# Impact of Chronic Opiate Use

- Enough Vicodin pills circulating in US for every adult to take 5/500 tab every 4 hours for 6 weeks
- Hyper analgesia
- Hypo sexual function
- Dependence, addiction, pseudo addiction
- Diversion
- Misuse and/or abuse
- Respiratory depression
- Deaths surpasses car crashes and homicides
  - Methadone most common overdose

# Bottom Line-Epidemiology

- If you prescribe -- you ARE responsible!!!
- No other med with as high risk profile and so little monitoring
- Every prescriber must use caution based on evidence and standards of care
  - No longer acceptable to prescribe as see fit
  - Oregon Medical Board findings: #1 opioid complaint is OVER and/or INAPPROPRIATE prescribing

# Multnomah County Health Department Case Study

- 3,000 patients on chronic opiates
- Alarming increase in opiate-related deaths
- Reports from patients of opioid misuse

# Approach

- Systematize safe and appropriate opiate prescribing
- Develop alternatives for treating pain
- Strengthen ties with addiction treatment
- Collaborate with other health care delivery partners to adopt new community norms
- Stimulate a community approach to the larger issues of chronic pain and addiction

# Key Changes

- Contraindications clearly outlined and must be followed
- Exceptions require review from Opiate Oversight Committee (OOC)
- All new patients screened and reviewed by OOC

# Contraindications

- Any history of diversion
- Opiate risk score:
  - High risk: >90% chance of developing problematic behaviors OR
  - DIRE score 7-13
- No Behavioral health screening done
- Undertreated Behavioral Health condition -- PHQ>15 and
  - No active treatment for active diagnosis
  - No engagement with Behavioral Health if initiated
  - Diagnosis not clear or defined
- History of suicide attempt in past 2 years or with pills any time
- Currently in Methadone Maintenance
- No functional improvement after trial or chronic use
- No complete work up for pain diagnosis
- History of misuse/ overuse
  - Receiving multiple Rx from different sites/ providers
  - Increased ER use for narcotics
  - Previous dismissal and/or narcotic agreement violation with another system, clinic, provider
  - Active substance abuse (including marijuana) as defined as any illicit or non-prescribed medication use in the past 12 months
- No non-medication therapies tried (at least 2 different modalities done in the past 12 months)

Any exceptions to above will be referred to OOC

# Ceiling Dose

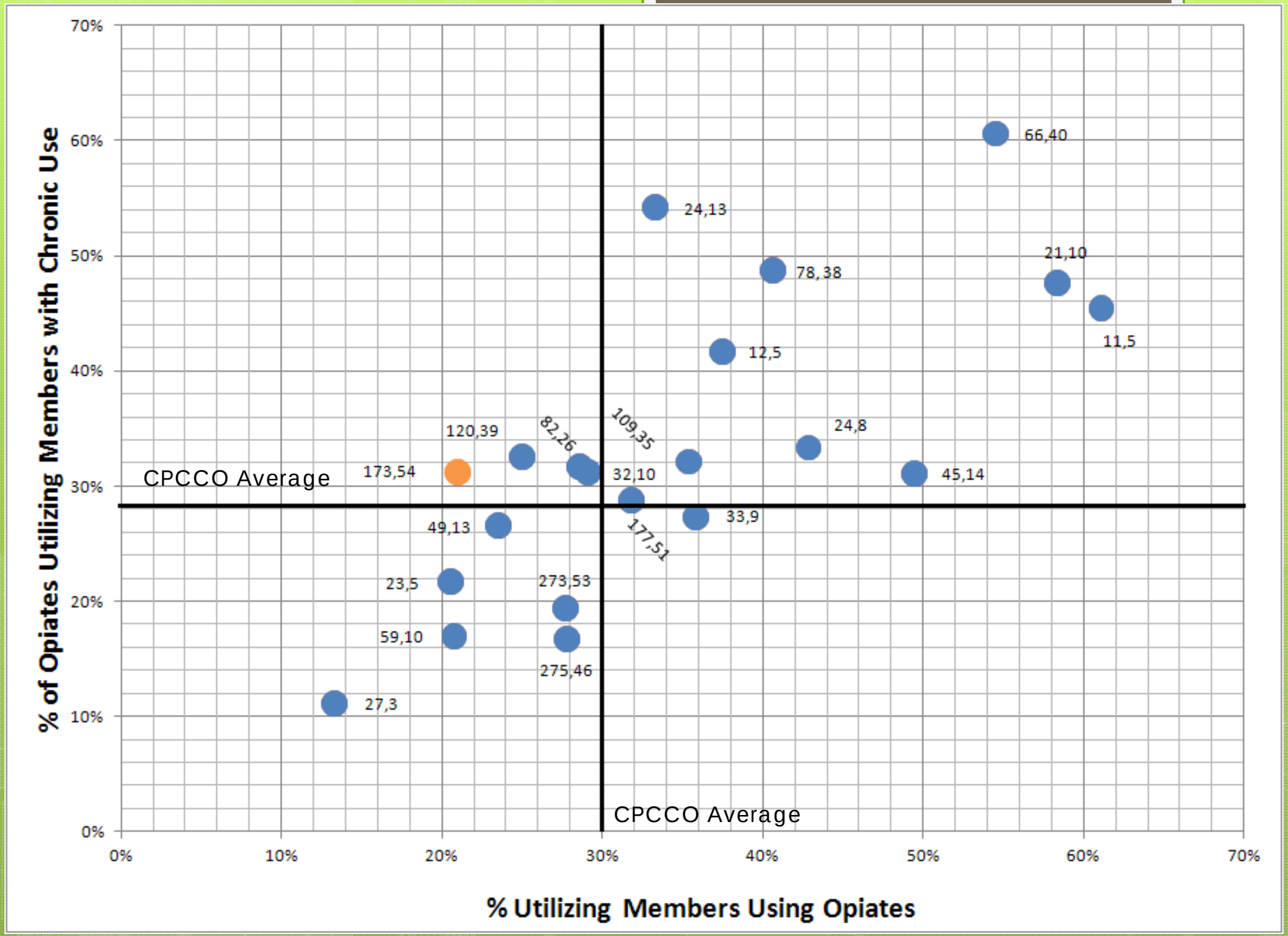
- Total opiate dose should not exceed 120 mg morphine equivalents per day (MED)
- All patient being prescribed more than 120 mg MED require a referral to opiate oversight committee
- Oregon moving to consistent standard developed by Washington state

# Plan Opportunities

- Health plans have unique opportunity to:
  - Understand risk and utilization from population perspective vs. individual patient perspective
  - Do interventions that support delivery system initiatives

# CareOregon Interventions

- Non-medication pain clinics
  - Behavioral Health based
  - Coordinated Care Organization intervention
- Pharmacy analytics
  - High total dose
  - Dangerous medication combinations
  - Medications from multiple providers
  - Methadone
  - Pharmacy “lock down”




(Opiate Users, Chronic Opiate Users)

# Jackson Care Connect

- CCO (Coordinated Care Organization) in Southern Oregon
- Owned by CareOregon
- Significant opiate overuse
- Community forum to address started by Public Health
  - Education, awareness
  - Development of guidelines, recommendations

# Jackson Care Connect

- Provider community responded need for plan to “enforce” 120 MED limit

- Created authorization process
  - Providers and patients sent letter at >120 MED
  - Providers need to submit a taper plan
  - If no plan in 60 days, medication refill denied
  - Provider requests for exceptions reviewed by JCC team
  - Patients could formally appeal

# Jackson Care Connect Learnings

- Decrease in members >120 MED
- Lots of community-provider angst
- Lots of direct support, technical assistance needed
  - Team of Medical Director, Nurse Care Manager, Pharmacist and **KEY: Behaviorist**
    - **For both patients and providers!**

## So what?
## Does any of this work?

- Oregon data
  - Deaths peaked in 2012 then slightly decreased
- Jackson County
  - Community moving toward standard
  - Programs developed to support population
- Multnomah County Health Department
  - Number of patients on opiates decreased 40%
  - 80% patient retention rate
- Multnomah County:
  - Heroin deaths greater than prescription opiates
  - Heroin deaths peaked in 2011, then steady reduction
  - Prescription-related deaths have fluctuated without a downward trend

# So what?
# Does any of this work?

- Local work led to Oregon-wide approach
- Creation of Community Standard
- Comprehensive payer approach (initially Medicaid -- broadening to Commercial)
- Strengthening Primary Care
  - Support and technical assistance to manage chronic pain

# Questions?

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# Managing Pain Safely (MPS)

Robert Moore, MD, MPH
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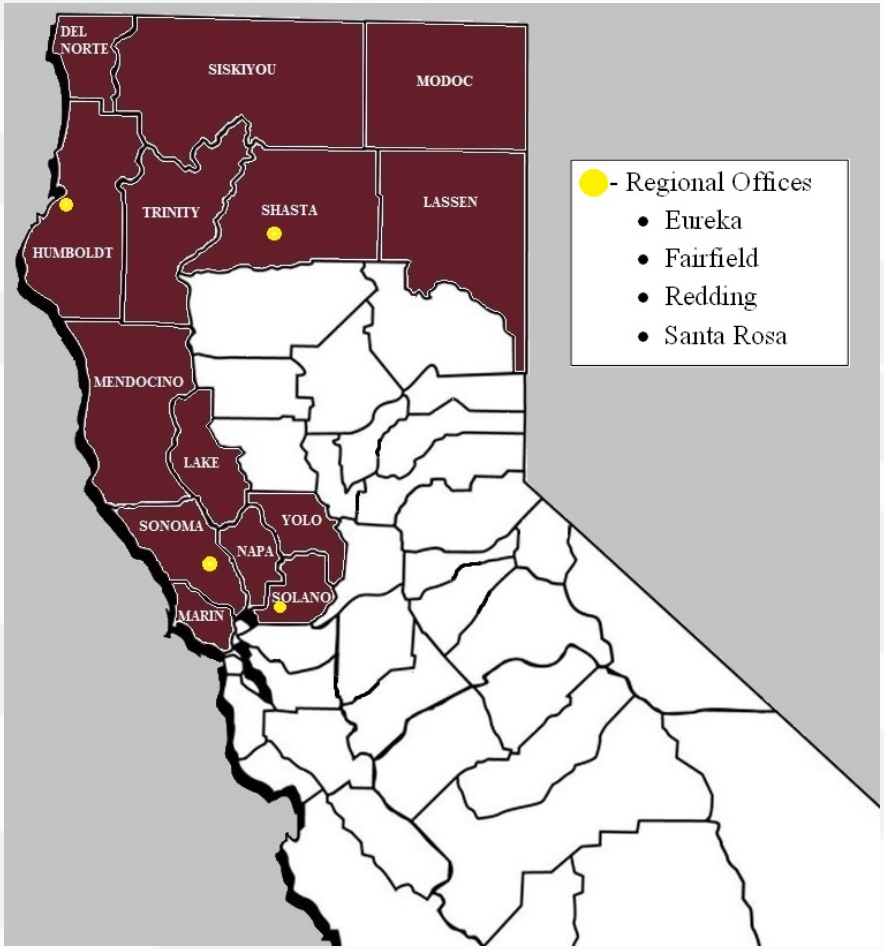
May 20, 2015

# About Us




- Medi-Cal Managed Care Plan
- County Organized Health System (COHS) Model
- Enrollment: 527,000 member
- Service Area: 14 counties
- Not for profit, governed by commission representing counties served
- Mission: To help our members, and the communities we serve, be healthy

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# How Successful Have We Been?

## Opioid Use

- From January to December 2014:
  - 36% reduction in use of Long Acting Opioids
  - 14% reduction in overall opioid drug use
  - Saving about $250,000 per month

## Health Outcomes

- 2014 (preliminary data) compared to 2013 (state confirmed)
  - Reduced non-suicide drug/alcohol overdose deaths by 28-35% in counties where we have data

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# Keys to Success

## Communicate a compelling need

- Rising overdose deaths (three-fold in last 15 years), surpassing automobile associated deaths
- Increased drug abuse from diversion (5% of all adults)
- Chronic opioids make chronic pain worse
- Three-fold increase in neonatal abstinence syndrome over last decade
- PCP visits for patients taking chronic opioids crowding out other patients, contributing to decreased PCP access and decreasing job satisfaction of many PCPs

## Provide a picture of success

- Case study:  Multnomah County, Oregon

## Communicate the path to success

- Disseminate best practices, customized to the audience

## Leadership commitment of energy and resources

## Add some aligned incentives

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# MPS – A Look Back at 2014

## March 2014 – Managing Pain Safely Initiative

- Goal – To optimize the use of medication and other modalities so that pain is treated appropriately, depending on the needs of the patient, informed by current medical science

- Developed PHC framework to tackle the problem
  - Steering Committee
  - 5 workgroups

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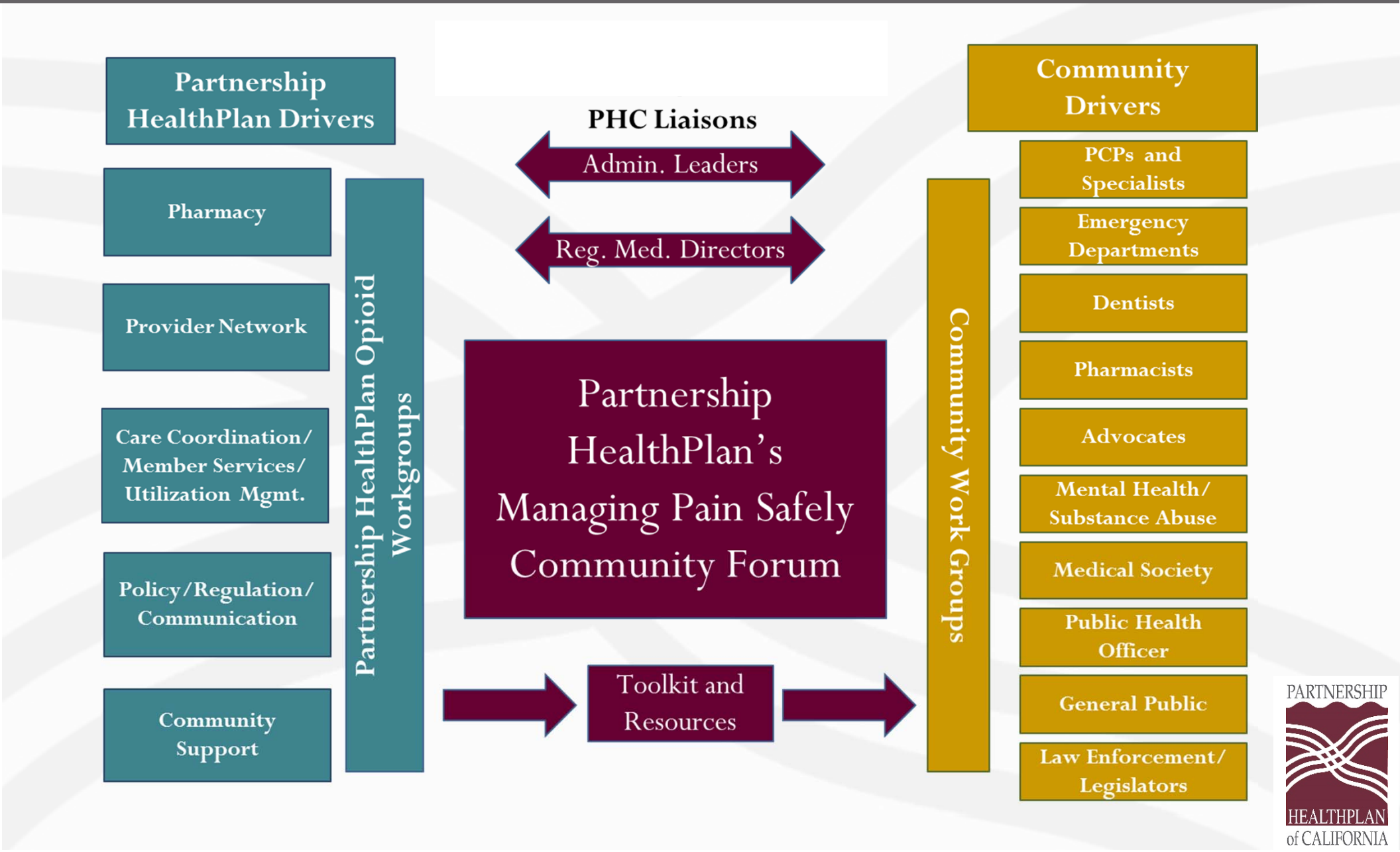
# Framework/Structure



# Our Five Workgroups

| | |
|---|---|
| **Pharmacy** | • Formulary Enhancements<br>  • TAR process to decrease inappropriate escalations<br>  • Identify medications to support tapering |
| **Provider Network** | • Survey providers to assess needs<br>• Develop provider toolkit<br>• Develop and offer educational opportunities |
| **Care Coord./UM/ Memb. Svcs.** | • Develop internal processes to support formulary changes<br>  • Care Coordination escalation team<br>  • Staff education (including process flow maps/scripts) |
| **Community Support** | • Support established community initiatives<br>• Initiate new community efforts |
| **Policy/Regs./ Communication** | • Serve as liaison to government representatives<br>• Coordinate opportunities for information sharing and raising awareness |

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# Interventions

- Education
- HealthPlan Pharmacy Prior Authorization Changes
- Additional options for treating pain
- Community activation
- Aligned incentives

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# Initiatives

## Education

- Prescribers
  - Primary Care Prescribers
  - Pain Specialists
  - Emergency Room Clinicians
  - Other Prescribers
- Other members of community
- Health Plan Board, Leadership Team, Staff
- Members (OUCH team- Outreach and Understanding Can Help)
- Public
- Elected representatives

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# Key Educational Messages

## Categories of Opioid Use

- New
- Escalating
- Continuing high-dose

## Changing understanding of how to use opioids

- Former understanding: “no maximum dose”
- Chronic use of opioids leads to hyperalgesia and decreased functioning

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# PCP Provider Education

- Phcprimarycare.org blog postings
- Email dissemination to medical directors of health centers and groups to forward to frontline providers
- In person CME events
- Webinars
- Recorded videos of trainings
- Provider newsletters
- In person regional meetings with Medical Director leadership
- Project ECHO (Extension for Community Health Outcomes)
- Safe Use Now:  Customized Provider Risk profiles and advice
- Toolkit on website:
  - http://www.partnershiphp.org/Providers/HealthServices/Pages/Managing-Pain-Safely.aspx

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# Pharmacy Changes

## Prior Authorization Changes: Preparation

- Internal alignment:  Pharmacists, Technicians, Medical Directors, Pharmacy and Therapeutics Committee
  - Comprehensive review of the literature
  - Debate, come to consensus on best practices

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# Pharmacy Changes Continued

## Prior Authorization Changes: Implementation

- Step I: Scrutinize justification for high doses of **expensive** opioids
- Step II: Scrutinize **escalation** of high dose opioids (no matter what the price)
  - Request justification for dose escalation, pre-approve stable dose
  - Only approve escalating dose with acceptable medical justification
  - Peer-to-peer conversations where-ever possible
- Step III: Scrutinize all prescriptions for all **stable** high doses of opioids
  - Request explanation for stable high dose
  - Difficult cases may require supporting documentation of mental health, pain specialist or pain medication oversight committee
  - Track responses with PHC-level Registry of patients on high dose opioids

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# Interventions

## Additional options for treating pain

- Expanded Benefits
  - Podiatry
  - Chiropractic
  - Acupuncture
- Formulary Changes
  - Duloxetine made formulary
  - Other adjunctive non-opioid treatments covered
- Behavioral Health
  - Smooth access to supportive behavioral health treatment
  - Mindfulness/Relaxation self help tools

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# Community Activation

## County Coalitions

- 8 of 14 PHC counties with active county coalitions
- Goals
  - Agree upon and disseminate standards for use of opioids and other controlled substances
  - Nurture sense of urgency at local level
  - Developed shared commitment to making improvement, with mutual accountability
  - Ensure all parts of community work together towards a common purpose, instead of working at odds with each other
- Essential elements:  convening organization; local leaders

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# Interventions

## Aligned Incentives

- Intrinsic Incentives
  - Stay on the right side of the Medical Board and Department of Justice
  - Increases PCP access: decreased time on patients with chronic pain to have more time to care for other patients
- Supplementary Financial Incentives
  - Primary care pay for performance program (PCP QIP)
  - Pharmacy QIP
  - 340B QIP

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# Looking Ahead in 2015

## April – December 2015

- Implementation of Safe Use Now
- Support development of local Pain Management Oversight Committees
- Develop a mechanism for categorizing patients on high doses of opioids for targeted treatments
- Piloting support for interdisciplinary teams to support opioid tapering
- Targeted interventions for patients newly prescribed opioids
- Pilot provision of eConsult services for complex patients on high dose opioids
- Continued offerings of educational opportunities
- Education and coordination around addiction screening and treatment
- Education of Hospitalists, Emergency Department Prescribers, Pharmacies

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# Long-Term Goals

## What have others achieved?

- Multnomah County, Oregon: 75% decrease in opioid use, 40% decrease in opioid overdose deaths over three years
- Kaiser: 91% decrease in high dose opioids for non-cancer, non-terminal pain over three years

## Other possibilities:

- Reduction in neonatal abstinence syndrome
- Decrease drug diversion

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# Questions?

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