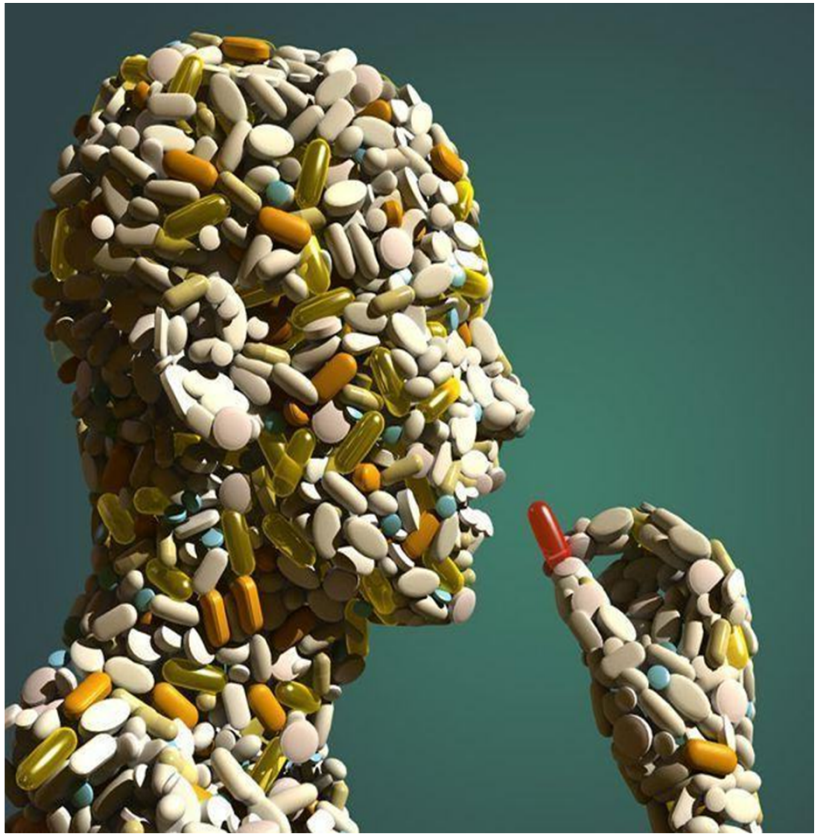
Ensuring Safe & Appropriate Opioid Use in Kaiser Permanente Patients & the Community



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Kaiser Permanente Medical Care Program

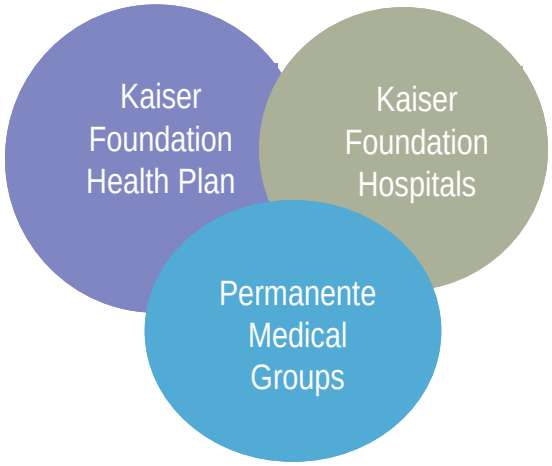
October 23, 2013

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

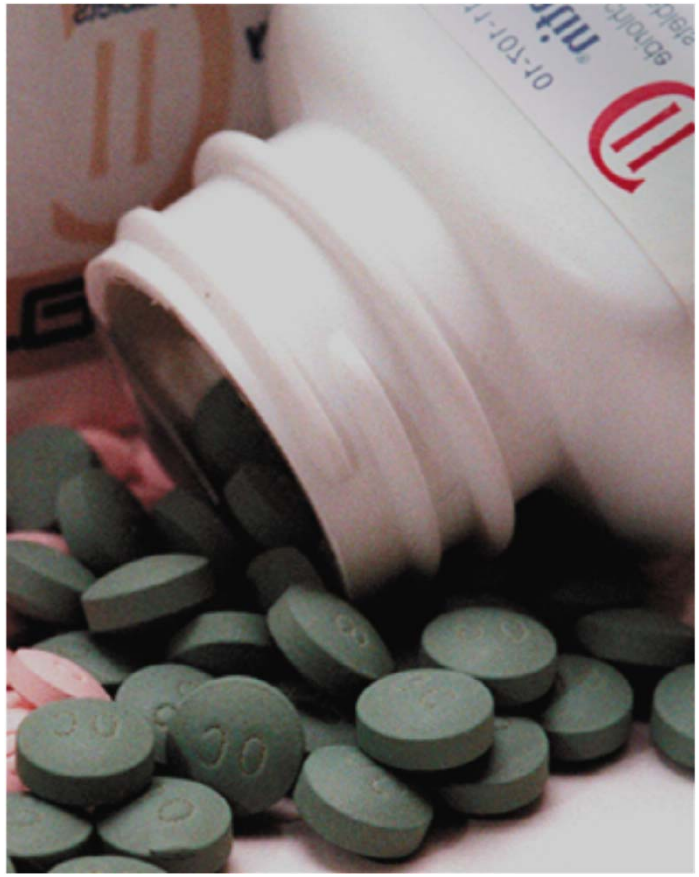
14 Kaiser Foundation hospitals

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 $\leq$ 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)

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

NOVEMBER 18, 2010

A Flood of Opioids, a Rising Tide of Deaths

Susan Okie, M.D.

Faced with an epidemic of drug abuse and overdose deaths involving prescription opioid pain relievers, the Food and Drug Administration (FDA)

In 2008, there were 14,800 prescription Painkiller-related deaths in the United States. (CDC)

Los Angeles Times

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.

Lori Smith of Aliso Viejo with photographs of her son Nolan, who died of a... (Liz O. Baylen / Los Angeles Times)

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.

Rxs involved in more deaths

Commonly abused prescription drugs are turning up more frequently in drug deaths. The frequency with which prescription anti-anxiety and pain drugs are involved in drug-induced deaths increased far more than cocaine and heroin between 2000 and 2008.

	% change 2000-08	Drugs
Prescription anti-anxiety drugs	+284%	Ativan, Klonopin, Valium, Xanax
What's going on: Replaced barbiturates in the 1950s for anxiety, insomnia and seizures. Treatment admissions for abuse tripled over the decade.		
Prescription pain drugs	+256%	OxyContin, Percocet, Vicodin, Norco, Dilaudid, Methadone
What's going on: These pain relievers are the most commonly prescribed drugs in the U.S. Treatment admissions for abuse are up fivefold over the decade.		
Cocaine	+68%	Cocaine, crack
What's going on: Increasing demand has led to shortages of this illicit drug.		
Heroin	+56%	Heroin
What's going on: Prescription drug abuse is fueling increased demand for this illicit drug as a cheaper alternative.		

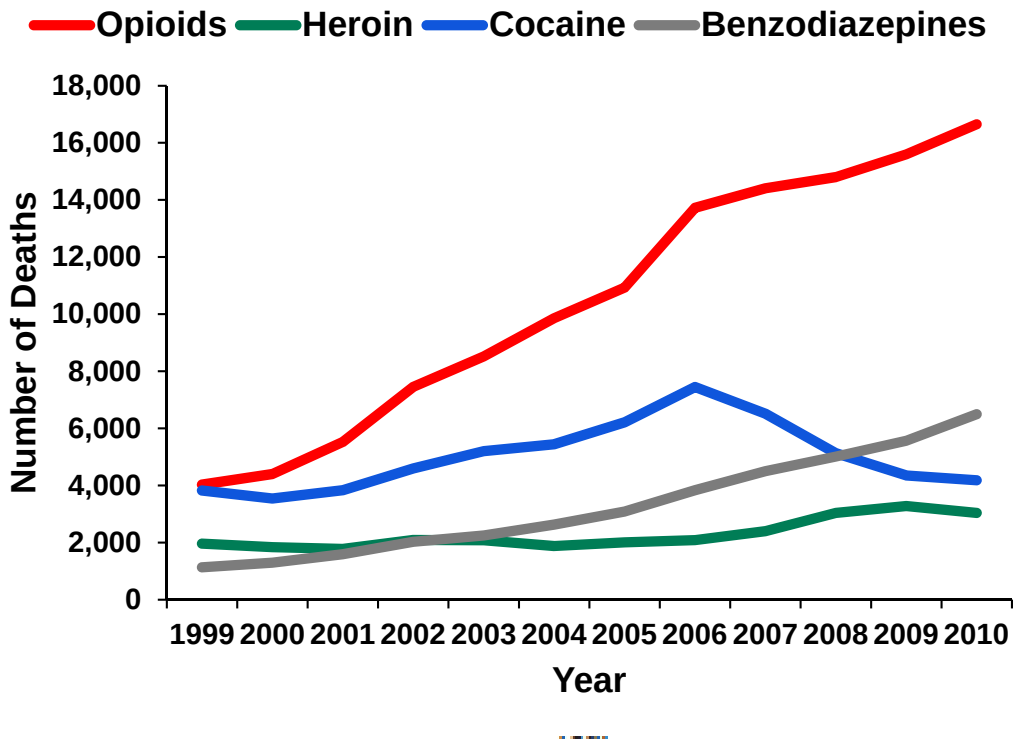
Note: More than one drug may be identified per death; a significant portion of drug-induced death certificates do not identify a drug by name.

Sources: U.S. death certificate data compiled in Multiple Cause Mortality files, 2000-2008, by the Centers for Disease Control and Prevention's National Center for Health Statistics; Times research

Morbidity and Mortality Weekly Report

CDC Grand Rounds: Prescription Drug Overdoses — a U.S. Epidemic

FIGURE 2. Number of unintentional drug overdose deaths involving opioid analgesics, cocaine, and heroin — United States, 1999-2010

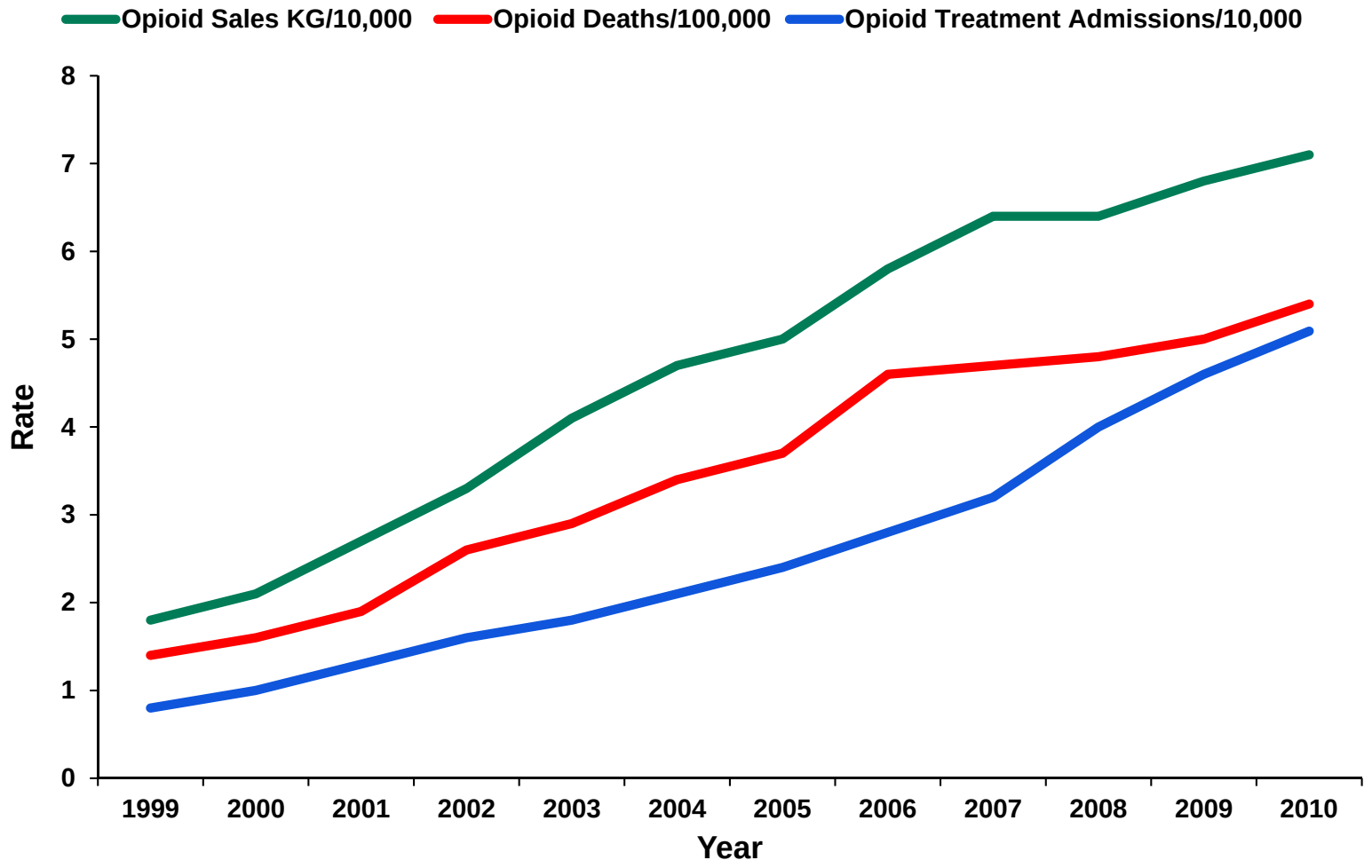


Source: National Vital Statistics System. Multiple cause of death dataset. Available at http://www.cdc.gov/nchs/nvss.htm.

More deaths from prescription opioids than heroin, cocaine, and benzo's combined

1/13/12 MMWR

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.
2. Source: Pain and Policy Studies Group. University of Wisconsin School of Medicine and Public Health. http://ppsg-production.heroku.com/
3. Manchikanti L, Singh A. *Therapeutic opioids: a te-year perspective on the complexities and complications of the escalating use, abuse, and nonmedical use of opioids.* 2008 Mar;11(2 Suppl):S63-88.

Evidence-based Chronic Pain Management

Evidence-Based Principles

- Opioids have proven efficacy and (relative) safety for treating acute pain and pain during terminal illness

- Opioids do NOT have proven efficacy or safety for treating chronic pain long-term

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

1. Ballantyne JC, Shin NS. Efficacy of opioids for chronic pain: a review of the evidence. *Clin J Pain*. 2008;24(6):469-478.
2. Ballantyne JC. Clinical and administrative data review presented to FDA May 30th and 31st 2012. 2012.
3. Noble M, Treadwell JR, Tregear SJ, et al. Long-term opioid management for chronic noncancer pain. *Cochrane Database Syst Rev*. 2010(1):CD006605.
4. Eriksen J, Sjogren P, Bruera E, Ekholm O, Rasmussen NK. Critical issues on opioids in chronic non-cancer pain: an epidemiological study. *Pain*. 2006;125:172-179.
5. Dillie KS, Fleming, MF, Mundt, MP, French, MT. Quality of life associated with daily opioid therapy in a primary care chronic pain sample. *J Am Board Fam Med*. 2008;21(2):108-117.
6. Toblin RL, Mack KA, Perveen G, Paulozzi LJ. A population-based survey of chronic pain and its treatment with prescription drugs. *Pain*. Jun 2011;152(6):1249-1255.
7. *Lee, et al., Pain Physician 2011; 14:146*
8. *Cochrane Collaboration (2010), Blue Cross Blue Shield and Kaiser Permanente Tec Assessment (2012)*

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

1. Chou R, Fanciullo GJ, Fine PG, et al. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain*. Feb 2009;10(2):113–130.
2. Sullivan MD, Ballantyne JC. What are we treating with chronic opioid therapy? *Arch Int Med*. 2012;172(5):433–434.

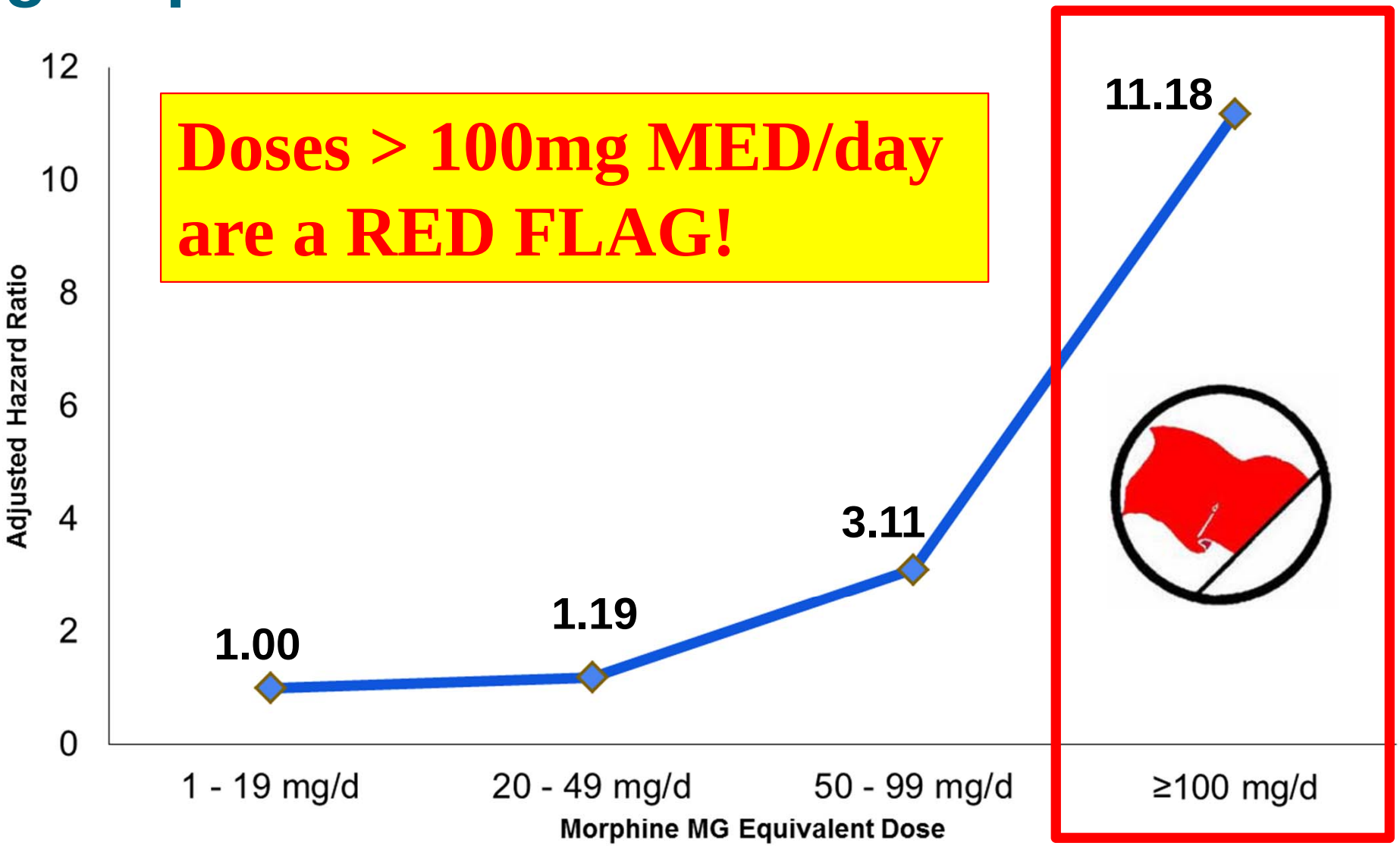
90 days is a key point

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

1. Turk DC, Okifuji A. Pain terms and taxonomies. In: Fishman SM, Ballantyne JC, Rathmell, JP eds Bonica's Management of Pain (4th ed) Lippincott Williams and Wilkins pp 14-23. 2010.
2. Braden JB, Fan MY, Edlund MJ, Martin BC, DeVries A, Sullivan MD. Trends in use of opioids by noncancer pain type 2000-2005 among Arkansas Medicaid and HealthCore enrollees: results from the TROUP study. *J Pain.* Nov 2008;9(11):1026-1035.
3. Korff MV, Saunders K, Thomas Ray G, et al. De facto long-term opioid therapy for noncancer pain. *Clin J Pain.* Jul-Aug 2008;24(6):521-527.
4. Martin BC, Fan MY, Edlund MJ, Devries A, Braden JB, Sullivan MD. Long-term chronic opioid therapy discontinuation rates from the TROUP study. *J Gen Intern Med.* Dec 2011;26(12):1450-1457.
5. Volinn E, Fargo JD, Fine PG. Opioid therapy for nonspecific low back pain and the outcome of chronic work loss. *Pain.* Apr 2009;142(3):194-201.

High Opioid Dose and Overdose Risk



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

Dunn et al. Opioid prescriptions for chronic pain and overdose. *Ann Int Med* 2010;152:85-92.

1. Morasco BJ, Duckart JP, Carr TP, Deyo RA, Dobscha SK. Clinical characteristics of veterans prescribed high doses of opioid medications for chronic non-cancer pain. *Pain.* Dec 2010;151(3):625-632.
2. Edlund MJ, Martin BC, Fan MY, Devries A, Braden JB, Sullivan MD. Risks for opioid abuse and dependence among recipients of chronic opioid therapy: results from the TROUP study. *Drug Alcohol Depend.* Nov 1 2010;112(1-2):90-98.
3. Weisner CM, Campbell CI, Ray GT, et al. Trends in prescribed opioid therapy for non-cancer pain for individuals with prior substance use disorders. *Pain.* Oct 2009;145(3):287-293.

Mayo Clinic Experience:

Pain Rehabilitation Center Treatment Outcomes

Medication Use by Patients

Medications	At Admission	At Discharge
Daily opioid (prescription) pain medications	57%	7%
Non-steroidal anti-inflammatory drugs (e.g., Ibubrofen)	46%	23%
Muscle relaxants	17%	3%

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.

Greater control over pain: 84%

Decrease pain severity <u>despite discontinuing pain meds</u>: 70%

Increase aerobic activity 93%

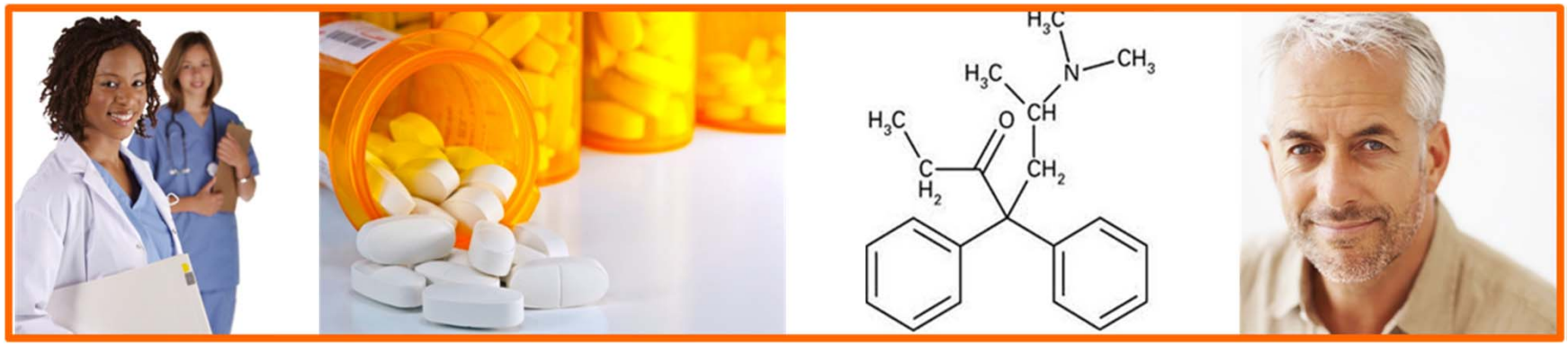
Decrease depression Rx's 80%

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

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

JUNE 2010

Medication News

for SCPMG Physicians

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.)*

The #1 Prescription Drug Abused in Schools...

Vicodin (brand name) is the number one prescription drug abused in schools. Patients who plan to resell brand name Vicodin and Norco will insist on the brand version, as the generic doesn't have the same "street value."

There is never a valid medical reason to prescribe brand name hydrocodone-acetaminophen, so when needed for pain, please only prescribe the generic form.

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 >>

Medication News is a monthly e-publication produced by SCPMG & Stakeholder Communications and SCPMG's Drug Utilization Action Team (DUAT). This publication is intended for SCPMG physicians. For feedback or comments, e-mail scpmg.communications@kp.org.

DUAT KAISER PERMANENTE DRUG UTILIZATION ACTION TEAM

Supporting Evid

EMR Decision-Support: Alternative Medication Alerts (2011)

Alternative Selection

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

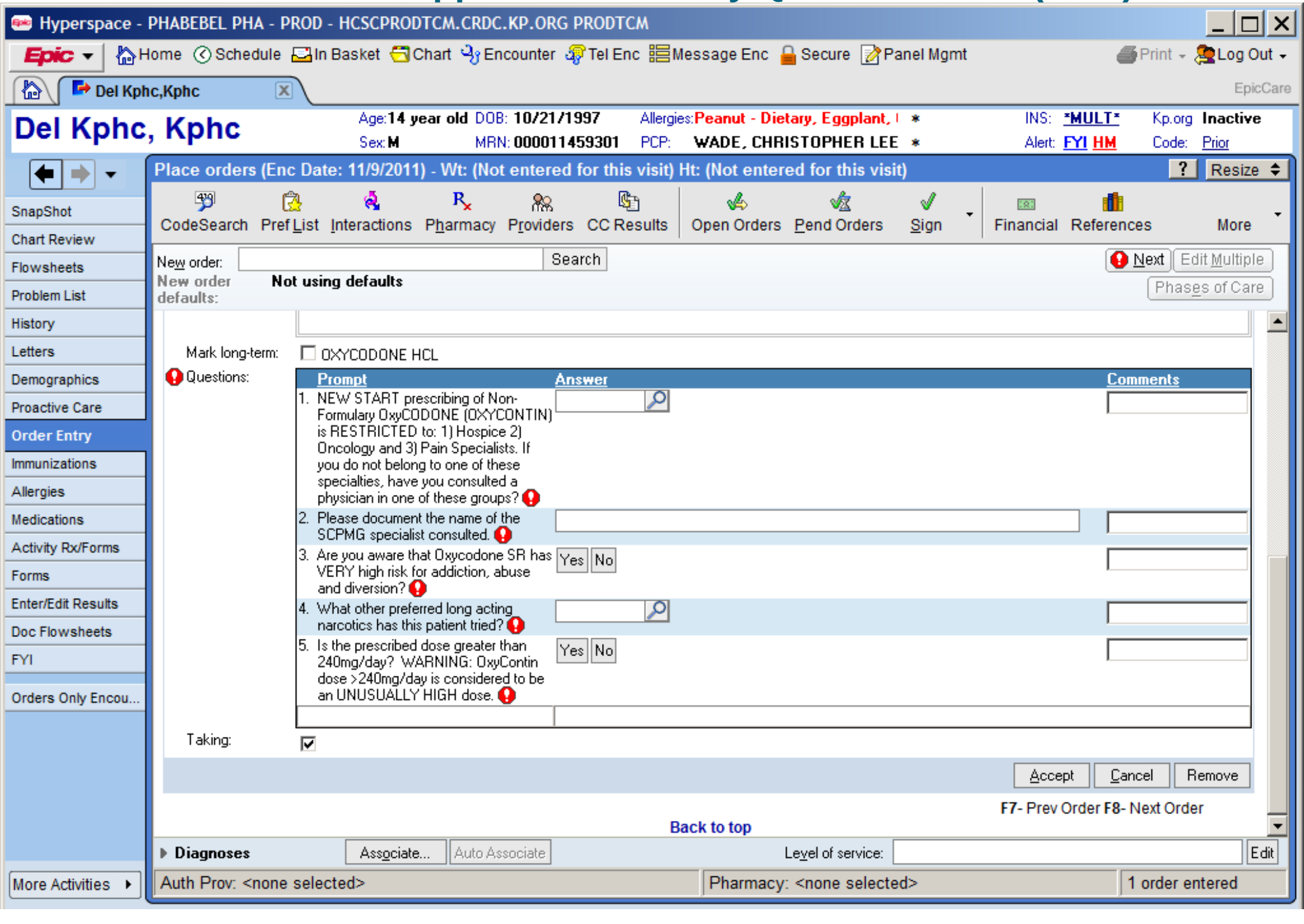
Web Links

OxyContin Medication Guide

Alternative	Sig	Disp	Refill	End Date	Class	Cost
MORPHINE 15 MG ORAL SR TAB	1 TAB PO Q12H	60	0			
MORPHINE 30 MG ORAL SR TAB	1 TAB PO Q12H	60	0			
MORPHINE 60 MG ORAL SR TAB	1 TAB PO Q12H	60	0			
MORPHINE 100 MG ORAL SR TAB	1 TAB PO Q12H	60	0			
FENTANYL 12 MCG/HR TD 72HR PATCH	APPLY 1 PATCH TO SKIN Q72H. REMOVE ...	5	0			
FENTANYL 25 MCG/HR TD 72HR PATCH	APPLY 1 PATCH TO SKIN Q72H. REMOVE ...	5	0			
FENTANYL 50 MCG/HR TD 72HR PATCH	APPLY 1 PATCH TO SKIN Q72H. REMOVE ...	5	0			
FENTANYL 75 MCG/HR TD 72HR PATCH	APPLY 1 PATCH TO SKIN Q72H. REMOVE ...	5	0			
FENTANYL 100 MCG/HR TD 72HR PATCH	APPLY 1 PATCH TO SKIN Q72H. REMOVE ...	5	0			
OXYMORPHONE 5 MG ORAL 12HR SR TAB	1 TAB PO Q12H ON AN EMPTY STOMACH....	60	0			
OXYMORPHONE 10 MG ORAL 12HR SR TAB	1 TAB PO Q12H ON AN EMPTY STOMACH....	60	0			
OXYMORPHONE 20 MG ORAL 12HR SR TAB	1 TAB PO Q12H ON AN EMPTY STOMACH....	60	0			
OXYMORPHONE 40 MG ORAL 12HR SR TAB	1 TAB PO Q12H ON AN EMPTY STOMACH....	60	0			

Accept Alternative | Continue With Original Order | Cancel Filing Process

EMR Decision-Support: Order Entry Questionnaires (2011)



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: OxyContin, 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 tracts narcotic and other controlled substance prescriptions.

If you need help with substance abuse or addiction, please call

1-888-724-7240

for confidential referral and treatment.

All the emergency departments in San Diego & Imperial Counties have agreed to participate in this important program.

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

IMPERIAL COUNTY MEDICAL SOCIETY

IMPERIAL COUNTY CALIFORNIA Public Health Department

HOSPITAL ASSOCIATION of San Diego and Imperial Counties

San Diego County Medical Society "Physicians United for a Healthy San Diego"

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

Working to spread this to other counties in California

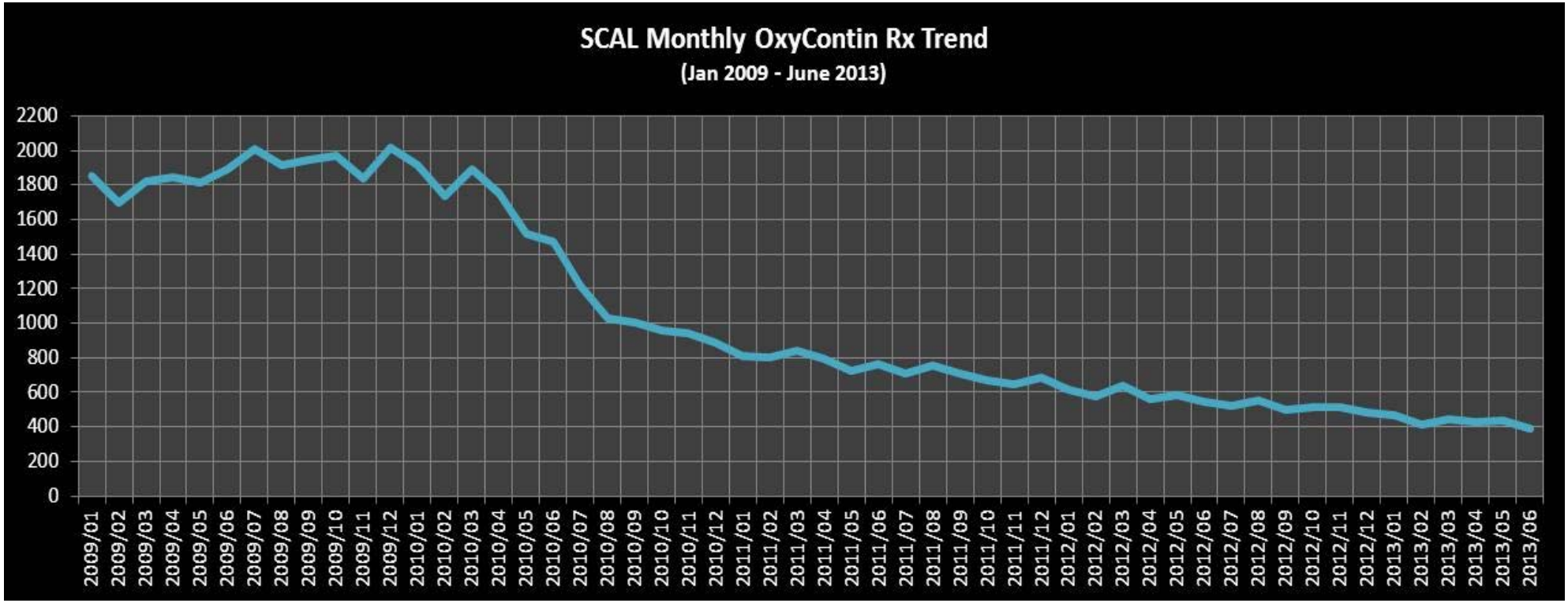
DUAT KAISER PERMANENTE DRUG UTILIZATION ACTION TEAM

Supporting Evidence Based Drug Use

Results to Date

Progress in Reducing High-Risk Opioids

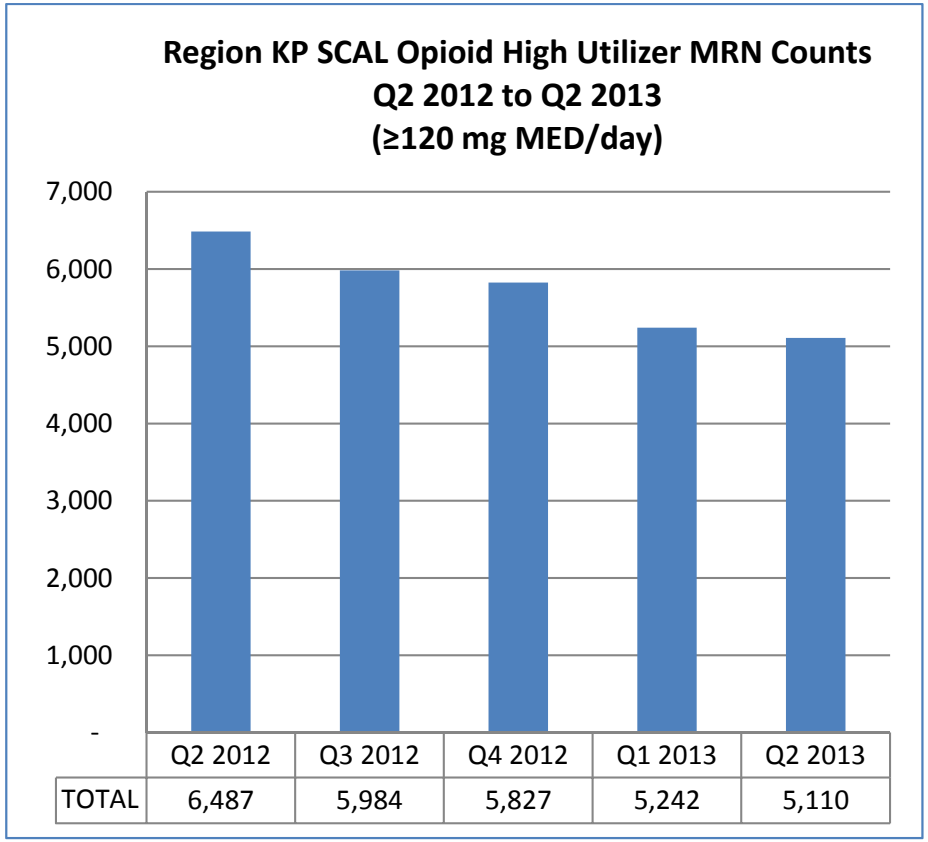
OxyContin Use Trending Down Since 2010 (- 80%)



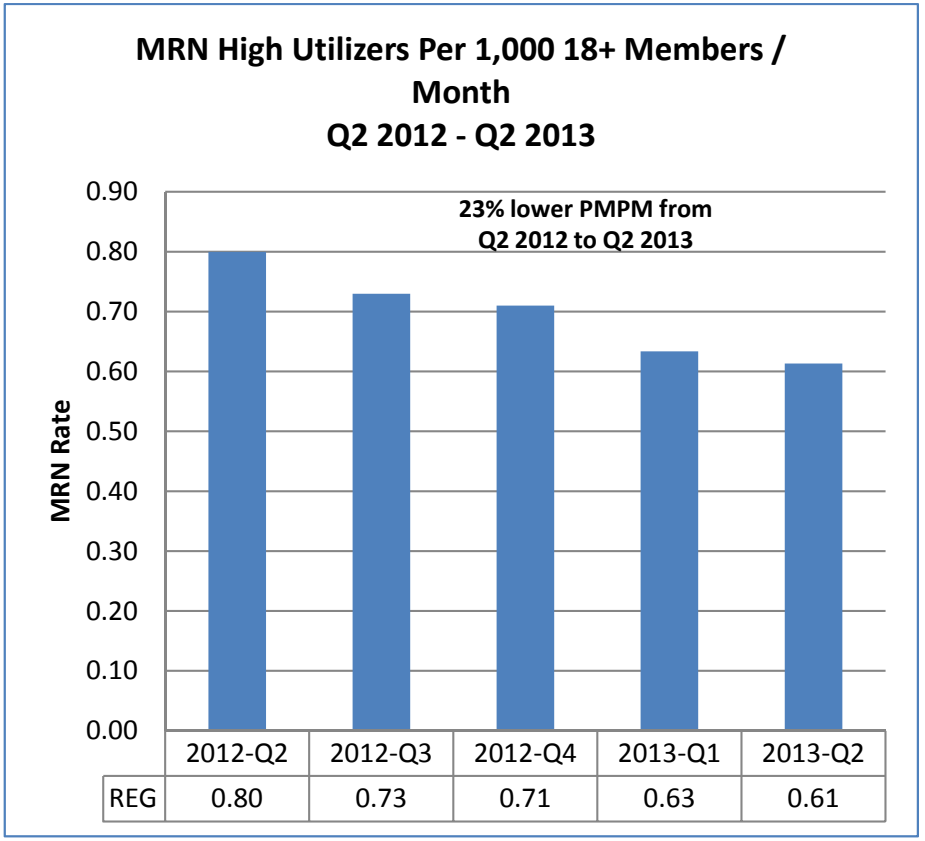
We have reduced the amount of Oxycontin in the community by over **100 million milligrams per year**, without reducing effective pain management.

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



	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013
TOTAL	6,487	5,984	5,827	5,242	5,110



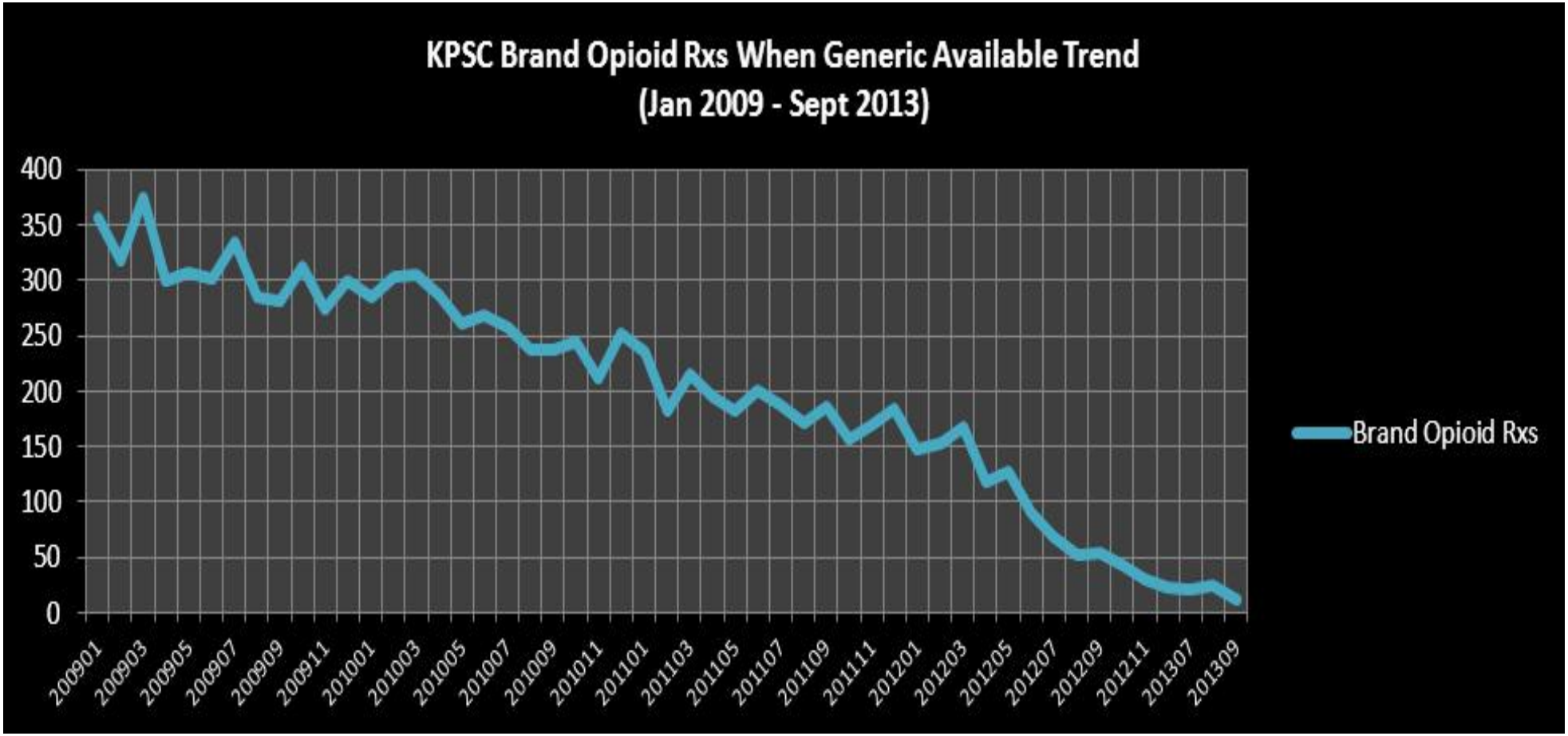
	2012-Q2	2012-Q3	2012-Q4	2013-Q1	2013-Q2
REG	0.80	0.73	0.71	0.63	0.61

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

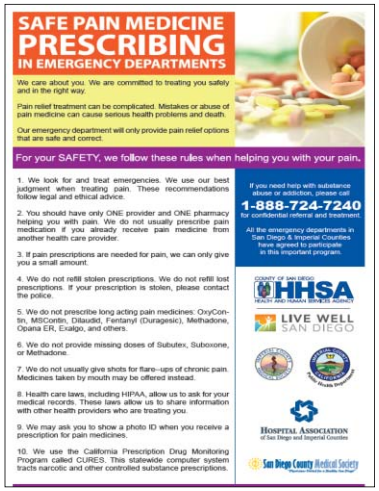


- Brand vs. generic Hydrocodone, oxycodone, and codeine with acetaminophen combination meds

What We've Learned

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

A Call to Community Action



KAISER PERMANENTE®

Scripps

CALIFORNIA STATE BOARD OF PHARMACY

CALIFORNIA HOSPITAL ASSOCIATION

CMA California Medical Association

COUNTY OF LOS ANGELES Public Health

CALIFORNIA ACEP
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

STATE OF CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS MEDICAL BOARD OF CALIFORNIA 1876

Health Services
LOS ANGELES COUNTY

Discussion