Implementing Safe Opioid Prescribing in Kaiser Permanente Northern California

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Clinical Lead, TPMG Opioid Initiative
Who We Are

Kaiser Permanente Northern California

- Over 4 million members
- 21 medical centers

The Permanente Medical Group (TPMG)

- >10,000 total physicians—largest medical group in the nation
- ~70 specialties and sub-specialties
- >200 medical offices and other outpatient facilities
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 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

- Adult and Family Medicine
- Emergency Department
- Orthopedic & Podiatric Surgery
- Lower Prescribing Service Lines
Opioid Safety Initiative – Leadership Structures

Executive Sponsor

MD Clinical Lead / Physician Education Specialist

Opioid Safety Leads:
One per each 15 service areas in NCAL

Champions + Chiefs:
Typically one of each per service line per each 21 medical centers

1000s of physicians across 21 medical centers

- Sets vision, strategy
- Stays updated on state and federal policy; evolving medical literature

- Help design and vet policies and recommendations
- Serve as local opioid safety experts for physicians & staff

- Facilitate roll out and adoption of opioid recommendations
- Help train and support physicians on workflows
Our Four-Pronged Approach to Opioid Safety

- Patient Education
- Physician Education + Support
- Patient Safety
- Community Protection
## Key recommendations

<table>
<thead>
<tr>
<th>Internal and Family Medicine</th>
<th>Emergency Department</th>
<th>Orthopedic Surgery</th>
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<tbody>
<tr>
<td><strong>New Pain Complaint:</strong></td>
<td><strong>Recommendations:</strong></td>
<td><strong>Recommendations:</strong></td>
</tr>
<tr>
<td>• Max 3 day supply of opioids for new pain complaints</td>
<td>• List of conditions for which opioids are not recommended</td>
<td>• Pursue pre-op tapering opportunities</td>
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<tr>
<td><strong>Chronic Pain:</strong></td>
<td>• No replacement of lost/stolen prescriptions</td>
<td>• No post-op ER/LA opioids</td>
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<tr>
<td>• Thorough intake eval</td>
<td>• Max 20 pills for acute pain (+PCP referral)</td>
<td>• Max two weeks Rx post-op</td>
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<tr>
<td>• 30 day max Rx</td>
<td>• Max 10 pills/3 days for chronic pain (+PCP referral)</td>
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<tr>
<td>• Medication agreement</td>
<td>• IV/IM opioids discouraged</td>
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<tr>
<td>• Consistent monitoring, documentation, and evaluation</td>
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<tr>
<td><strong>Analytics:</strong></td>
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<td><strong>Analytics:</strong></td>
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<tr>
<td>• Monthly reports on all patients &gt;50MME</td>
<td>• Monthly dashboard showing Rx (pills) and IV/IM by prescriber by chief complaint</td>
<td>• Periodic reports on post-op prescription size by prescriber by procedure</td>
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</tbody>
</table>
## 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**

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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 predetermined 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
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 | Increased availability of Naloxone for higher risk patients |
| 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 |

- **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

| Strateigic 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 |
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
## Key measures of success

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

Carol Havens, MD
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### Adult & Family Medicine Opioid Workflows:
Patients with Chronic Non-Cancer Pain

<table>
<thead>
<tr>
<th>New Start - Acute Pain</th>
<th>New Start - Chronic Pain</th>
<th>Ongoing Assessment and Management of Chronic Opioid Therapy (COT) - Chronic Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If opioids are indicated prescribe:</strong></td>
<td><strong>Chronic Opioid Therapy Assessment:</strong></td>
<td>1. Physical exam</td>
</tr>
<tr>
<td>Short acting opioids</td>
<td>1. Patient hx, pain hx, physical exam</td>
<td>2. 5A's Assessment</td>
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<tr>
<td></td>
<td>2. Validated patient self assessment tool (ex: SOAPP, ORT)</td>
<td>3. CURES</td>
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<td></td>
<td>3. CURES</td>
<td>4. Assess for alcohol dependence</td>
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<td></td>
<td>4. Assess for alcohol dependence</td>
<td>5. Urine Drug Screen</td>
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<td></td>
<td>5. Create Treatment Plan</td>
<td>6. PHQ-9 or equivalent (PRN)</td>
</tr>
<tr>
<td><strong>After 2 months:</strong></td>
<td><strong>If benefits outweigh risk:</strong></td>
<td><strong>For patients who did not have a chronic opioid therapy assessment prior to beginning COT,</strong> ensure patient hx, validated self assessment tool, and Opioid Medication Agreement are completed.</td>
</tr>
<tr>
<td>Do Chronic Opioid Therapy Assessment.</td>
<td>1. Opioid Medication Agreement</td>
<td>7. Revisit treatment plan and modify as needed</td>
</tr>
<tr>
<td></td>
<td>2. Prescribe max 30 day supply</td>
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**Beware of the 90 day cliff**

*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

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.

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.

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 or 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.
TPMG Opioid Safety Initiative—Orthopedic Surgery

In order to further improve the safety of our patients, we have developed a set of opioid safety recommendations in the Pre-Operative and Post-Operative areas.

**Pre-Operative**
- Patient optimization
- Taper consideration
- Expectation setting

**Intra-Operative**
- Not focus of this initiative
- Mainly ERAS

**Post-Operative**
- Consistent, conservative Rx at discharge
- Consistent monitoring
- Seamless handoffs with PCPs
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Description</th>
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<tr>
<td><strong>Pre-Op Recommendation</strong></td>
<td>Explore pre-operative opioid tapering for patients on chronic opioids referred for elective surgery</td>
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<tr>
<td><strong>Post-Op Recommendation 1</strong></td>
<td>Avoid ER/LA opioids</td>
</tr>
<tr>
<td><strong>Post-Op Recommendation 2</strong></td>
<td>Conservative prescribing and enhanced monitoring</td>
</tr>
<tr>
<td><strong>Post-Op Recommendation 3</strong></td>
<td>Pursue multi-modal pain control whenever possible</td>
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<tr>
<td><strong>Post-Op Recommendation 4</strong></td>
<td>Effectively manage post-op surgical pain &amp; coordinate with PCP</td>
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