Team-Based Approach to Caring for Patients on Chronic Opioid Therapy

Kaiser Permanente Northwest

Sean Jones, MD

Katie Reese, PharmD

We have no disclosures.

Objectives

1. Describe patient centered approaches to decreasing opioid doses
2. Identify the benefit from multidisciplinary opioid management approach
3. Describe the value of peer reviews and clinician-to-clinician feedback
4. Describe the benefit of a unified system-wide culture change to address new thinking in chronic pain management and opioid safety

Our "Undoing Project"

Kudos to Michael Lewis for shedding light on the work of Tversky and Kahneman

Medical community now humbled by our embrace of the expansion of opioid use for chronic pain in the 1990s

It takes one person to make a mess but a team to clean it up

Although we have been successful in reducing opioid use and avoiding new starts, we recognize the ongoing challenge of managing chronic pain. Other options are not always effective or tolerated

Background-Kaiser Permanente noted growing use of opioids for pain management in the mid 2000s and began system wide efforts to manage opioid population

- **Opioid Stewardship programs focus on:**
  - Limiting opioid prescriptions (28, 14, 7 day supplies)
  - 2009 Opioid Therapy Plan criteria and pre-visit summary metrics defined and care gaps fire
  - 2010 STORM training sessions with all primary care clinicians
  - 2010 Pill count required for early refills

Background

- 2011 KPNW sets daily dose threshold of 180 MME for chronic non-malignant pain
- 2012 Stop escalations above 120 MME
- 2013 Set “hard” ceiling of 120 MME for max dose for chronic non-malignant pain
- 2014 224-tablet limit per dispense for opioids and 30 day supply restrictions
- 2015 Default quantities for ED and UCC is set to 12 tablets

Background

- 2015 Order Entry Alerts for long-acting new starts
- 2016 "Stage-setting" letter campaign for members on >90 MME
- 2016 System Quality targets reduction in % patients >90 MME and total quantity opioid tablets dispensed
- 2017 "Stage-setting" letter campaign for members on >90 MME and benzodiazepines
- STORM pharmacist reviews all patients >300 MME and works with physician leads as needed

Why a pharmacist team

Escalating drug costs related to long term use of opioids in non-malignant pain.

Communities recognizing risks of opioids

Limited role for opioids in management of chronic pain

Changing view of chronic pain and management options

Primary Care Clinicians could not do this work alone

+

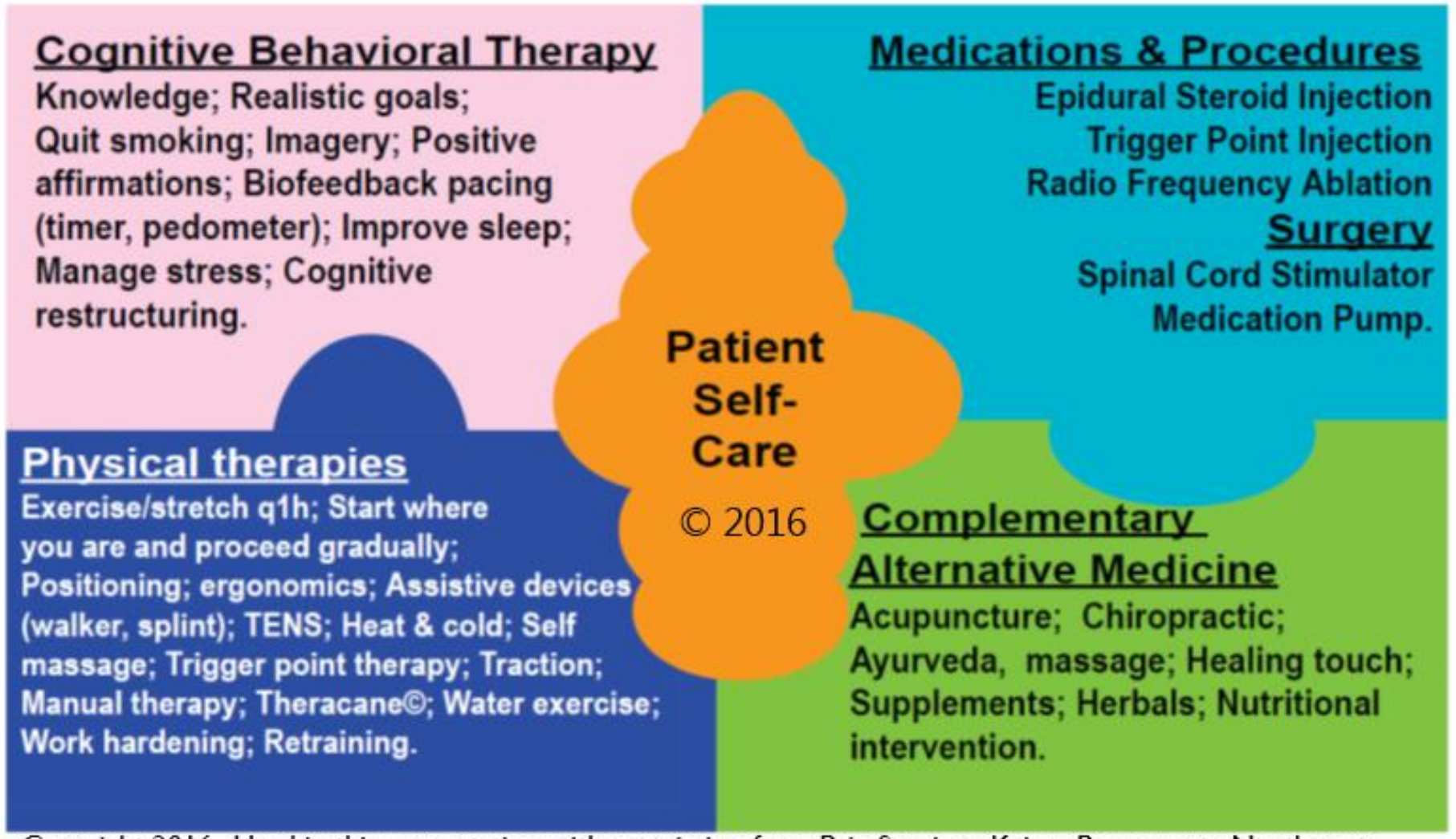
=

Pharmacists are well-poised to:

- navigate other pain management opportunities
- individualize taper plan
- direct pt follow up for pain and withdrawal mgmt
- coordination with Primary Care, pharmacy, specialty

KPNW Pain Management Support Program

Chronic Pain: Multimodal Therapy



Process:

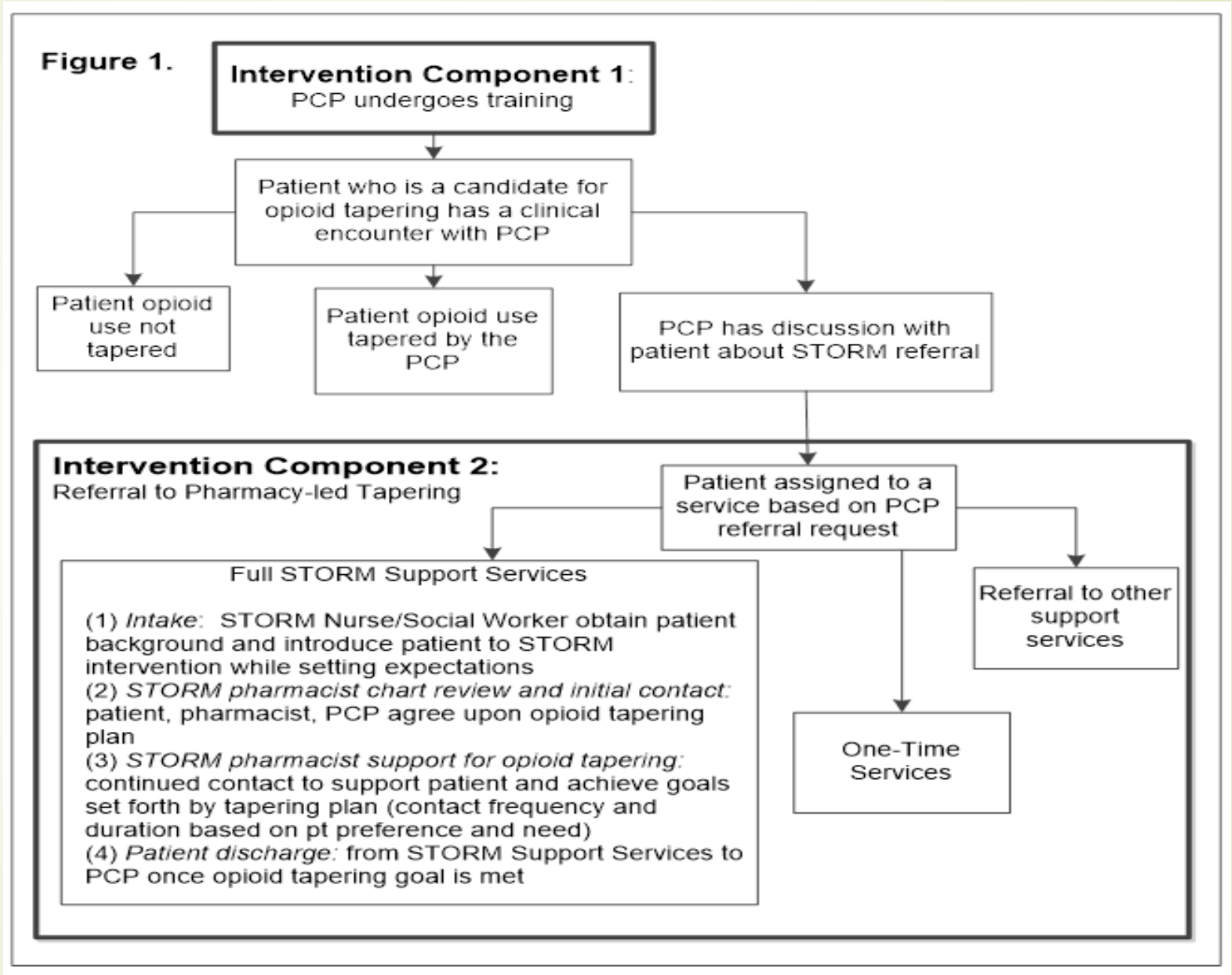
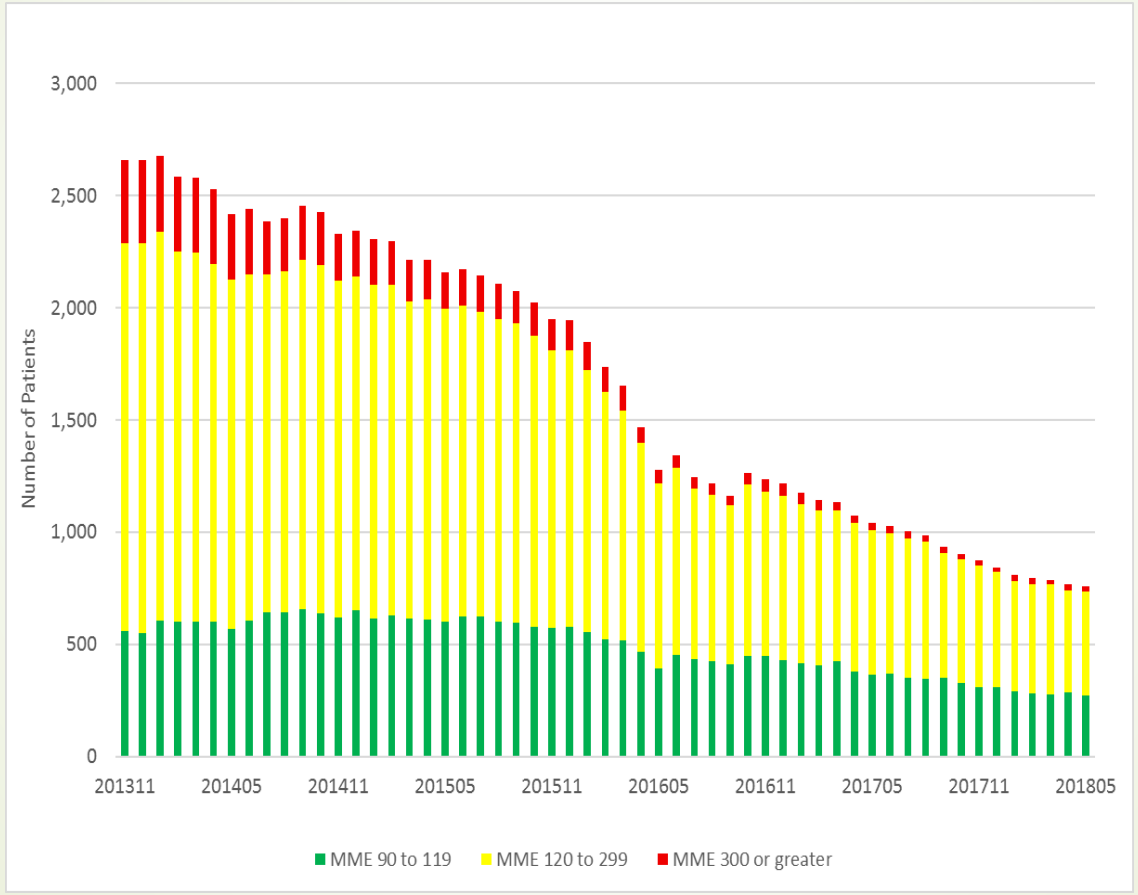


Figure 1.
Intervention Component 1:
PCP undergoes training
Patient who is a candidate for opioid tapering has a clinical encounter with PCP
Patient opioid use not tapered
Patient opioid use tapered by the PCP
PCP has discussion with patient about STORM referral
Intervention Component 2:
Referral to Pharmacy-led Tapering
Patient assigned to a service based on PCP referral request
Full STORM Support Services
(1) Intake: STORM Nurse/Social Worker obtain patient background and introduce patient to STORM intervention while setting expectations
(2) STORM pharmacist chart review and initial contact: patient, pharmacist, PCP agree upon opioid tapering plan
(3) STORM pharmacist support for opioid tapering: continued contact to support patient and achieve goals set forth by tapering plan (contact frequency and duration based on pt preference and need)
(4) Patient discharge: from STORM Support Services to PCP once opioid tapering goal is met
Referral to other support services
One-Time Services

Goals

- Opioid dose reductions
- Support patients to improve safety, function, and pain control
- Reduce medication costs
- Improve clinician satisfaction

Outcomes



- >300 MME: 94% decrease
- >90 MME: 77% decrease

Outcomes

2009: Average daily MME = 96.8

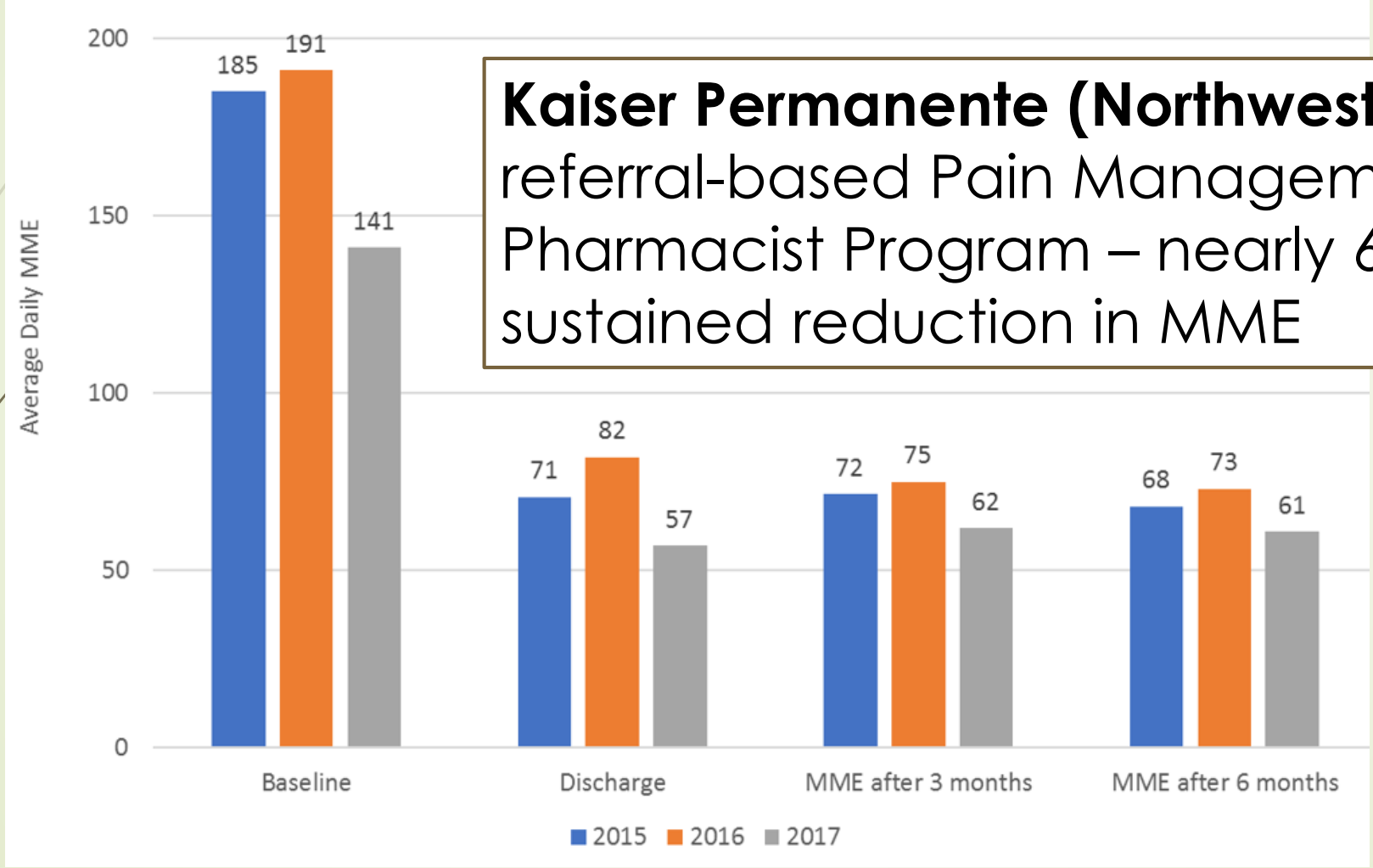
2018: Average daily MME = 36.6

Outcomes

- 46% decrease in # of patients with chronic concurrent benzodiazepine/opioid use from 2014 to 2017

- >500 new referrals and >4500 patient interventions per year

Outcomes



Kaiser Permanente (Northwest)
referral-based Pain Management Pharmacist Program – nearly 60% sustained reduction in MME

Clinician Satisfaction

96% of clinicians agreed pharmacist-led sessions changed how they manage patients with chronic nonmalignant pain

Patient Satisfaction

53% of patients stated that they could participate in more activities important to them; 80% rated their pain as improved or unchanged as a result of the taper.

Patient Testimonial

"I am so grateful to you. I was afraid to taper, and I wondered, 'Why me?' Now, though, I am so glad I did. It forced me to find other ways to manage my pain, and now my pain has improved, I am healthier than I have ever been, I'm sleeping better—and I owe it all to you."

Patient Testimonial

https://youtu.be/I4Sl-_5bzUc

Latest Efforts: Clinician Peer Feedback

- Top 14 prescribers of MME >90
- Pharmacist chart review
- Clinician leadership/pharmacist meeting
- Clinician peer feedback and development of action plan
- Prescriber/patient discussion

Goal of Chart Review

Identify underutilized alternatives:

-self care, CAM, PT, non-opioid meds, behavioral health, pain clinic

Clarify Highest risk patients- prior overdose, substance use disorder, multiple sedatives with COPD/Sleep apnea

Highlight possible misuse- unsanctioned dose escalations, unexpected drug screens, early refills, lost/stolen

Make specific recommendations regarding taper/discontinuation and alternatives

Clinician Peer Feedback

141 patient reviews

81 resulted in tapering

42 resulted in referrals to STORM Team

14 No longer fit criteria

Conclusions

Collaboration teamwork between PCPs, pharmacists, nurses, social workers and physician peers can significantly impact opioid prescribing to the benefit of the individual patient, the prescriber, and to the public health.