Narcotics Safety Initiative

opioid overuse, chronic pain, and what Plans can do about it

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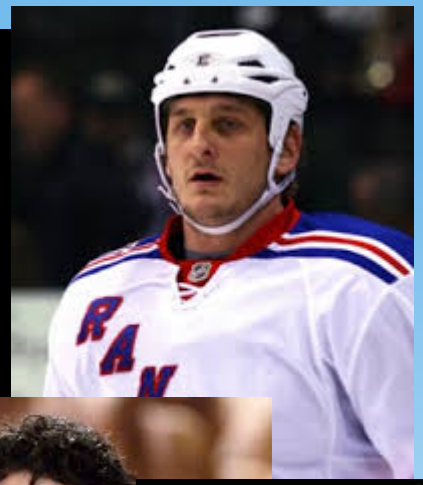
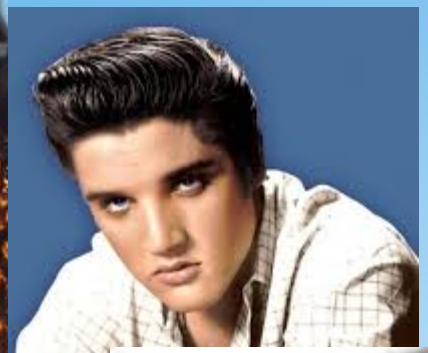
blue of california


Judy Garland
1922-1969






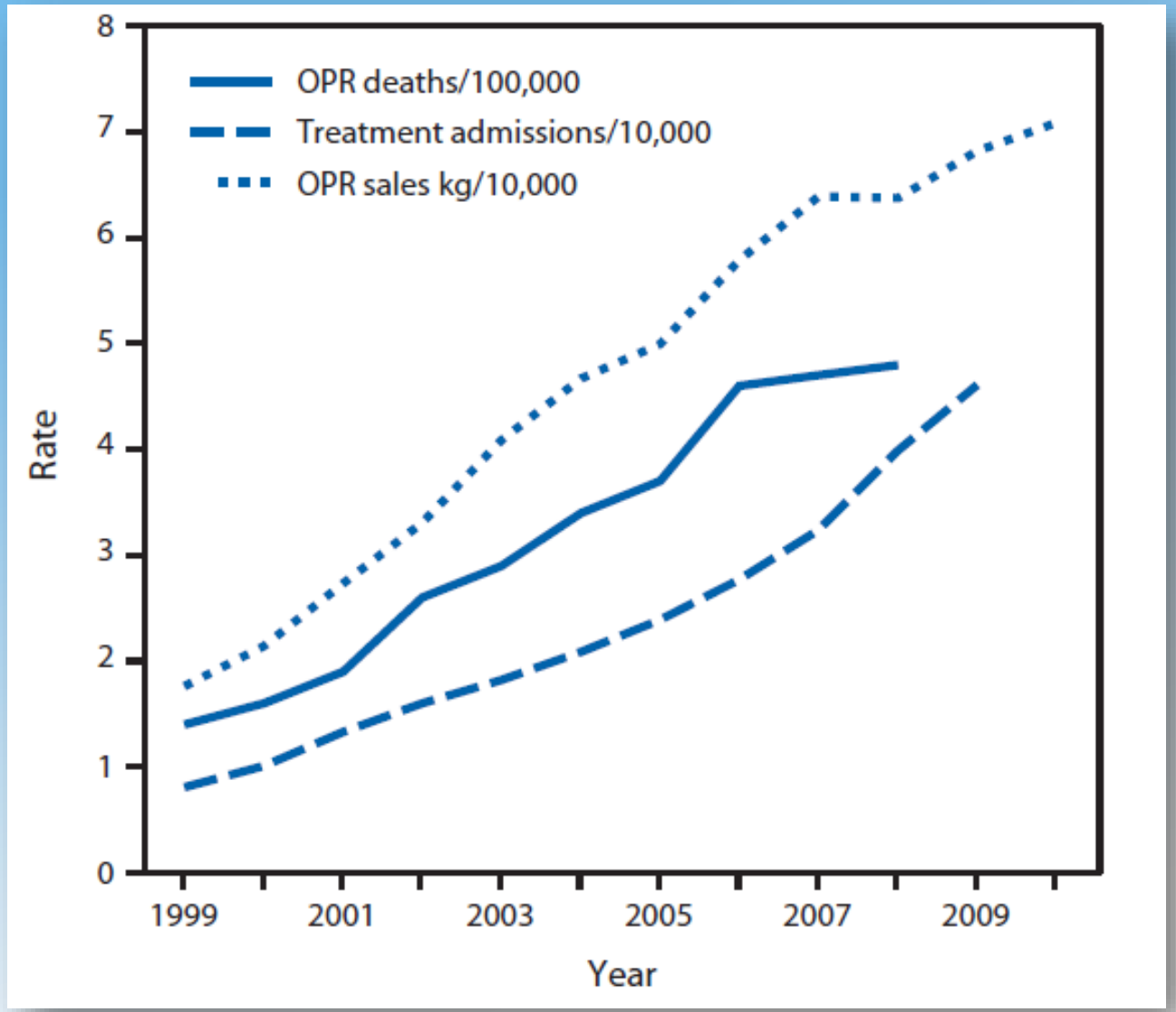






Gerald Levert

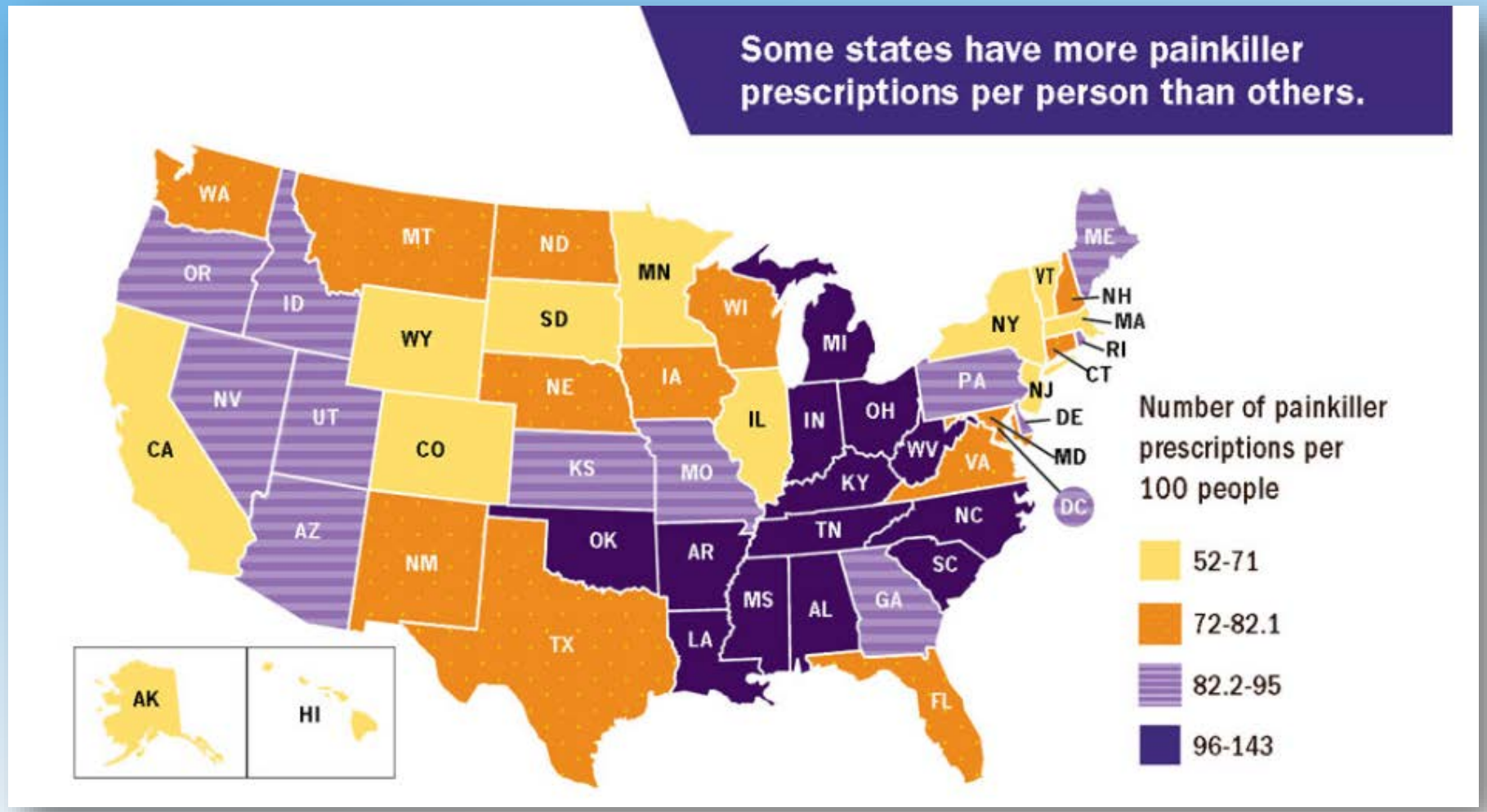
Opioids Kill People



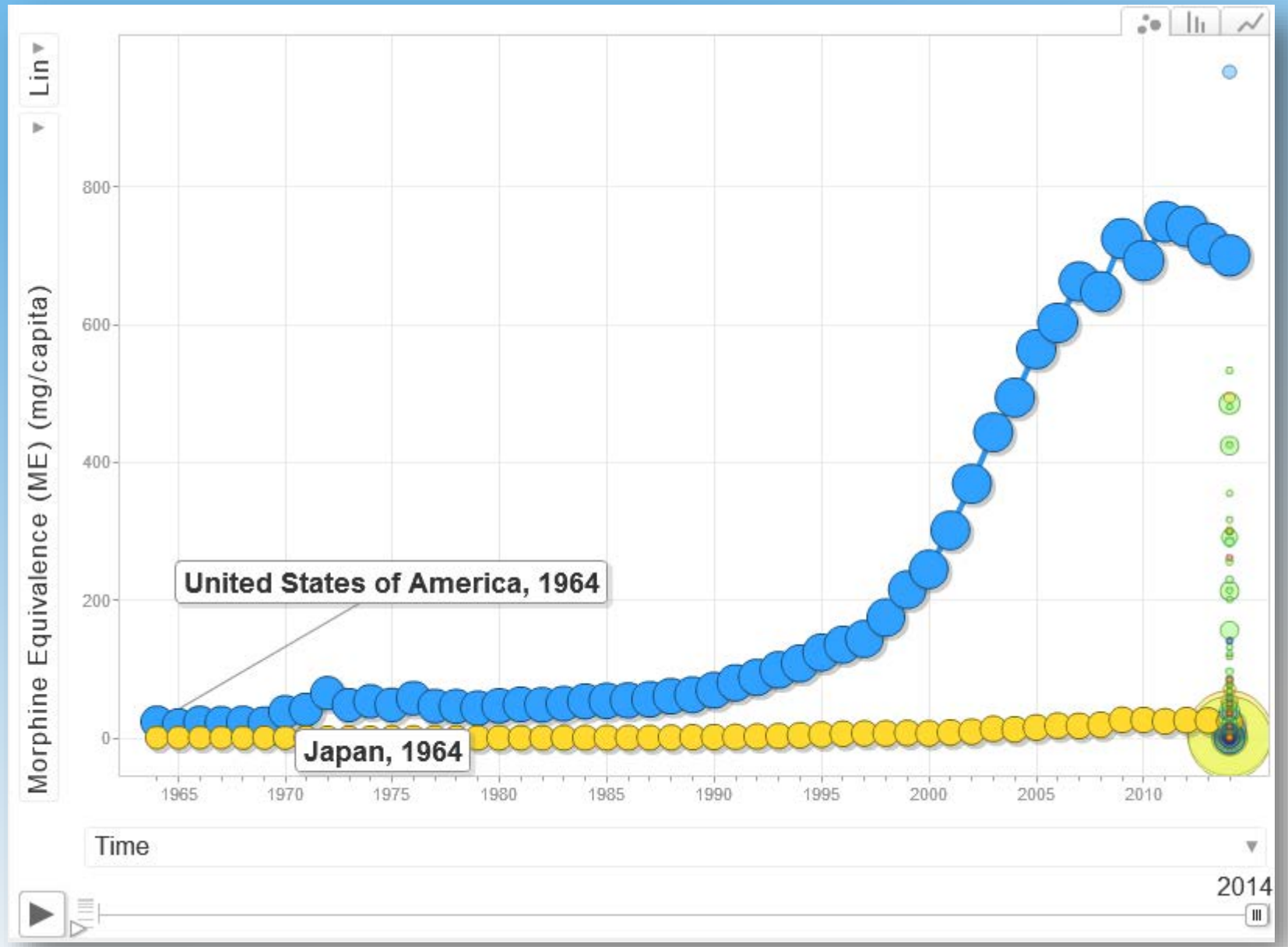
MMWR, 2011, US data

Age-adjusted rates per 100,000 population for opioid pain reliever (OPR) deaths, crude rates per 10,000 population for OPR abuse treatment admissions, and crude rates per 10,000 population for kilograms of OPR sold.

California Less Severely Impacted



The Full Historical and Cultural Perspective



https://ppsg.medicine.wisc.edu/chart

Recipe for Disaster – Change Beliefs

1980	1995	2010
Opioids have high risk of addiction.	Opioids have low risk of addiction.	Opioids have high risk of addiction.
"Addiction" = tolerance, physical dependence, and withdrawal syndrome ("habit forming")	"Addiction" = persistent drug seeking behavior despite evidence of harm (DSM IV)	"Addiction" = persistent drug seeking behavior despite evidence of harm
Avoid chronic opioid use.	Opioids "safe and effective" for chronic pain.	Opioids neither safe nor effective for chronic pain.
Manage pain to preserve function and reduce suffering, using multiple modalities.	Eliminate pain. Pain causes pain. "Pain is the fifth vital sign."	Manage pain to preserve function and reduce suffering, using multiple modalities.

Our Prior Strategy

We responded . . .

introducing Blue Shield's Narcotics Safety Initiative

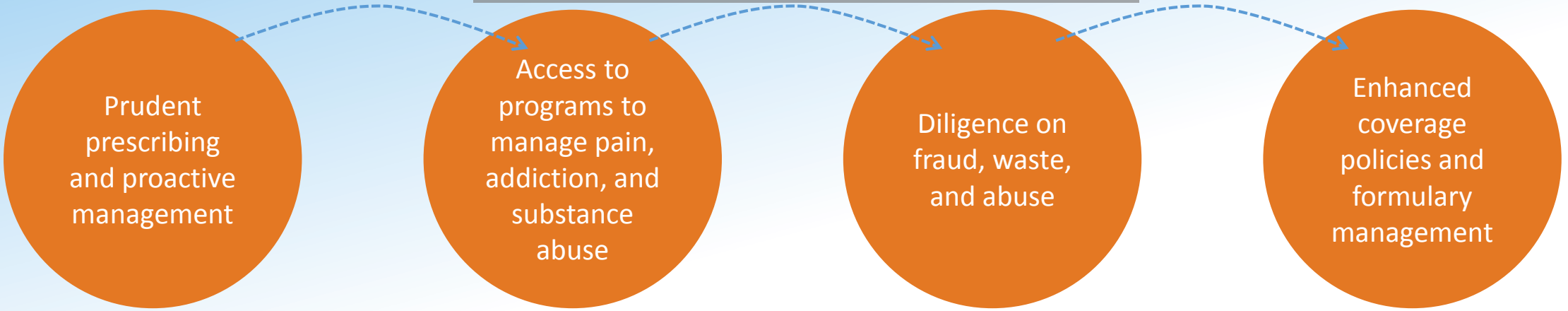
A three-year effort to reduce opioid use by 50%
among Blue Shield members with non-cancer pain
by end of 2018

Reduce the number of people on chronically high doses of opioids

Prevent progression to chronic use for members newly starting opioids

Reduce the number of prescriptions and refills for members newly starting opioid

Through evidence-based interventions



Goals / Objectives

↓ opioid use by 50% among Blue Shield members with non-cancer pain by end of 2018

Dosage	Chronic Use	Prevention	Consumption
↓ people on chronically high doses of opioids	↓ average MED per Rx for chronic utilizers	Prevent progression to chronic use for members newly starting opioids	↓ Overall consumption of opioids
Goals Year 1 vs. 2014 baseline			
-10% > 500 MED -5% 100-500MED -15% total	**-5%**	**-10%**	**-10% (kg MED per 10k mbrs)**

2015 Plan – what we accomplished

CURES sign-up events with CA DOJ in ACOs

Webinars for providers about NSI initiative and activities

Formulary and prior authorization (PA) enhancements

- Added PA for extended-release opioids, including Oxycontin
- Limit new Rx's to 120 mg MED/day
- Enhanced PA criteria to align with the Federation of State Medical Boards guidelines

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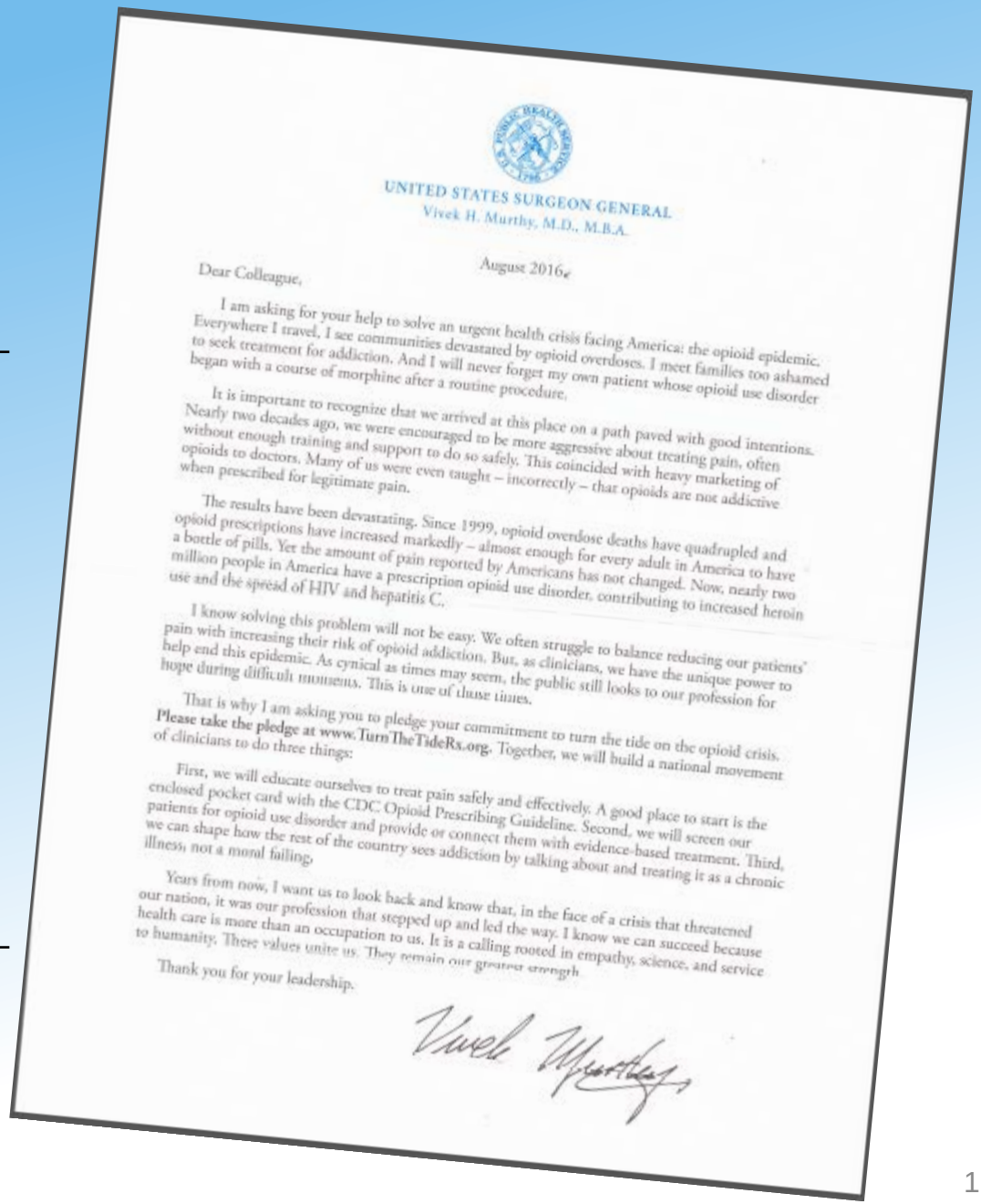
Established narcotic outlier case review workgroup with Blue Shield of CA multi-disciplinary staff (clinical, quality and investigators)

- Some ACOs implemented their own narcotic case review committees, some led by pharmacists

2015 Plan – what we accomplished

Participated in national, state & local task forces

- U.S. Surgeon General's Opioid Roundtable Dec. 2015
- Panelist at a Senate Health, Education, Labor and Pensions (HELP) Committee briefing on BCBSA initiatives
- Safe Med LA coalition and San Diego/Imperial County task force



UNITED STATES SURGEON GENERAL
Vivek H. Murthy, M.D., M.B.A.

August 2016

Dear Colleague,

I am asking for your help to solve an urgent health crisis facing America: the opioid epidemic. Everywhere I travel, I see communities devastated by opioid overdoses. I meet families too ashamed to seek treatment for addiction. And I will never forget my own patient whose opioid use disorder began with a course of morphine after a routine procedure.

It is important to recognize that we arrived at this place on a path paved with good intentions. Nearly two decades ago, we were encouraged to be more aggressive about treating pain, often without enough training and support to do so safely. This coincided with heavy marketing of opioids to doctors. Many of us were even taught – incorrectly – that opioids are not addictive when prescribed for legitimate pain.

The results have been devastating. Since 1999, opioid overdose deaths have quadrupled and opioid prescriptions have increased markedly – almost enough for every adult in America to have a bottle of pills. Yet the amount of pain reported by Americans has not changed. Now, nearly two million people in America have a prescription opioid use disorder, contributing to increased heroin use and the spread of HIV and hepatitis C.

I know solving this problem will not be easy. We often struggle to balance reducing our patients' pain with increasing their risk of opioid addiction. But, as clinicians, we have the unique power to help end this epidemic. As cynical as times may seem, the public still looks to our profession for hope during difficult moments. This is one of those times.

That is why I am asking you to pledge your commitment to turn the tide on the opioid crisis. **Please take the pledge at www.TurnTheTideRx.org.** Together, we will build a national movement of clinicians to do three things:

First, we will educate ourselves to treat pain safely and effectively. A good place to start is the enclosed pocket card with the CDC Opioid Prescribing Guideline. Second, we will screen our patients for opioid use disorder and provide or connect them with evidence-based treatment. Third, we can shape how the rest of the country sees addiction by talking about and treating it as a chronic illness, not a moral failing.

Years from now, I want us to look back and know that, in the face of a crisis that threatened our nation, it was our profession that stepped up and led the way. I know we can succeed because health care is more than an occupation to us. It is a calling rooted in empathy, science, and service to humanity. These values unite us. They remain our greatest strength.

Thank you for your leadership.

Vivek Murthy

We partnered with ACO providers & pharmacists to change prescribing

Prescribers

- Review CA CURES patient reports prior to prescribing
- Conduct interdisciplinary clinical case reviews
- Refer to programs & resources

Blue Shield

Provide…

- Actionable reports identifying high risk patients
- Connections to programs & resources

Patient centered medication management

Pharmacist providers

- Advise in interdisciplinary clinical case reviews
- Care coordination

Behavioral Health Providers

Year 1 results

↓ opioid use by 50% among Blue Shield members with non-cancer pain by end of 2018

Dosage	Chronic Use	Prevention	Consumption
↓ people on chronically high doses of opioids	↓ average MED per Rx for chronic utilizers	Prevent progression to chronic use for members newly starting opioids	↓ Overall consumption of opioids
Goals Year 1 vs. 2014 baseline			
-15%	**-5%**	**-10%**	**-10% (kg MED per 10k mbrs)**
Actuals			
-15% met	**-5% met**	**-25% exceeded**	**-5.9% on track**

Year 2 goals

↓ opioid use by 50% among Blue Shield members with non-cancer pain by end of 2018

Dosage	Chronic Use	Prevention	Consumption
↓ people on chronically high doses of opioids	↓ average MED per Rx for chronic utilizers	Prevent progression to chronic use for members newly starting opioids	↓ Overall consumption of opioids
Year 1 vs. 2014 baseline			
-15% -10% on >500 MED -5% on 100-500 MED	**-5%**	**-10%**	**-10%** **(kg MED per 10k mbrs)**
Year 2 vs. 2014 baseline			
-45% -30% on >500 MED -15% on 100-500 MED	**-10%**	**-30%**	**-30%** **(kg MED per 10k mbrs)**

2016 Plan

Formulary Benefits

- Lower max dose limits for Medicare members to 120 mg MED/day effective 1/1/2016
- Lower new-start dose limits from 120 to 90 mg MED/day
- Tighter refill threshold for opioids (must finish 90% of Rx supply before refill, instead of 75%)
- >30 days supply of any opioid Rx no longer allowed
- >15 days supply of opioid Rx for acute condition not allowed (ex. cough/cold)
- Access to naloxone (opioid overdose rescue)
- Access to medication-assisted treatment (MAT) with methadone, buprenorphine

2016 Plan

Evaluate medical utilization and clinical outcomes

Implement enhanced provider reports on narcotic prescribing/use

- Custom reports for Provider Partners

Develop a Patient Review & Coordination (PRC) program ("lock-in") with DMHC guidance for 2018 roll-out

Establish a network of preferred chronic pain management programs for BSC prescribers/members

- Also offer member-directed self-engagement programs

Offer mentoring/training programs to prescribers on opioid tapering

Identify & share provider group best practice programs/activities

Thank You