

APPENDIX 6



PAIN CARE REPORT

An Analysis of Pain Medication Prescribing at CDCR Institutions during April 2010 and November 2010.



Quality Management Section
501 J Street
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Report Issued: March 2011

Pain Care Report

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Introduction

In September of 2010, California Prison Health Care Services (CPHCS) released the first Pain Care Report to provide institution healthcare managers and line staff with timely, relevant, and actionable information to improve pain management. The first Pain Care Report analyzed the use of non-opioid, opioid, and adjunctive medications at all 33 adult institutions during the month of April 2010. This second Pain Care Report compares pain medication prescribing rates in April 2010 and November 2010 and describes changes in prescribing practices between these months.

Pain care is considered a priority patient safety and quality improvement area for a number of reasons, including, but not limited to:

- Risk of drug diversion noted in several overdose cases, leading to deaths and potentially avoidable hospitalizations;
- Wide variation in prescribing of short-acting and long-acting narcotics and adjunctive medications among CPHCS providers and prisons;
- Workload for pharmacy and nursing staff related to resource-intensive dispensing and administering requirements for controlled drugs, including crushing and observation;
- Workload for staff involved in processing inmate appeals;
- Wide variation in documentation by providers of the clinical justifications for prescribing narcotics and gabapentin;
- Medicolegal requirements by the California Medical Board regarding proper documentation and treatment of patients with chronic pain and cancer-related pain.

The April 2010 Pain Care Report found that nearly one-third of CPHCS patients statewide were taking pain medications. At six institutions, one in five inmates was prescribed either an opioid or adjunctive medication. Variation in prescribing practices was significant across the state, which could not be explained by complexity of medical mission, suggesting that institutions had not fully implemented the CPHCS pain guidelines, issued in December of 2009.

With the release of the April 2010 Pain Care Report, CPHCS provided institutions with standardized decision support to help institutions implement guidelines and improve care, such as the following:

- **Pain Care Guide** for Primary Care Teams, a distillation of the pain care guidelines designed to remind Primary Care Teams of important aspects of care and includes a summary of treatment goals, medication information, treatment algorithms, and patient self-management information;

- **Pain Management Quality of Care Review Tool**, an audit tool that can be applied during chart reviews to assess whether the documentation of providers' care aligns with CPHCS guidelines and medicolegal requirements; and
- **Template for Pain Management Committee documentation.**

In addition, many institutions implemented local quality improvement initiatives to bring prescribing practices into alignment with guidelines. Institutions produced lists of patients on pain medications and reviewed patient charts to ensure that care was appropriate, conducted staff development exercises, established Pain Management Committees for group review of complex cases, and raised awareness about the CPHCS pain care guidelines with inmate groups, and other activities.

In another important development since the release of the first Pain Care Report, CPHCS converted gabapentin to non-formulary status. In May 2010, a court determined that the pharmaceutical company that produces gabapentin had systematically distorted evidence supporting off-label use, including selective reporting of trial results. Upon review of the full medical evidence, gabapentin was not found to be convincingly or consistently effective for several typical off-label uses, such as treatment of neuropathic pain or migraine prophylaxis.

Please see the section entitled "Recommendations," which offers additional activities to support further improvements in pain care.

Data Sources and Methodology

Drugs identified for this study were opioid and adjunctive medicines in the CPHCS Pain Management Guidelines that were noted to be among the top 200 most commonly prescribed medications statewide. Please see Table 1 for specific drugs by category.

Table 1. Identified Drugs

Category	Drugs
Opioids:	Acetaminophen with Codeine, Methadone, Morphine, Oxycodone, and Tramadol
Adjunctives:	Carbamazepine, Gabapentin, Methocarbamol, and Oxcarbazepine

- The figures in this report are based on medications dispensed in April 2010 and November 2010.
- Guardian is the source of the pharmacy data analyzed in this report.
- Unduplicated patient counts are based on the institution where the medication was dispensed.
- Category and statewide patient counts are unduplicated between drugs and institutions. Individuals receiving different drugs within a category are counted only once in the category.
- Overall totals for patients prescribed pain medications are unduplicated across all drug categories.
- Statewide counts are unduplicated between institutions in cases where a patient may have received a medication in more than one facility.
- Institution names are abbreviated in this report. Table 6 in the Appendix provides a list of all abbreviations and the full title for each institution.

Major Findings

- The most significant changes in prescribing opioids occurred at a subset of institutions that were among the highest and lowest utilizers in April 2010. These changes were particularly significant at a subset of institutions where clinical leadership collaborated with staff at headquarters to improve compliance with pain guidelines.
- Five institutions that were among the highest opioid utilizers in April 2010 (CMF, PVSP, SVSP, DVI and CCWF) decreased opioid prescribing an average of 34 percent, with a range of 20 percent to 51 percent, by November 2010.
- The seven institutions with lowest rates of opioid use in April 2010 (LAC, PBSP, SCC, CCC, CEN, CMC and ASP) increased prescribing by an average of 27 percent, with a range of 2 percent to 85 percent, in November 2010.
- There have been significant reductions in individual institutions' adjunctive prescribing rates especially among the highest utilizers such as PVSP and KVSP.
- At seven institutions (CAL, CMF, DVI, ISP, SATF, RJD and VSPW), a decrease in opioid prescribing was associated with an increase in adjunctive prescribing.

Recommendations

Please consider the following activities when making further improvements in pain care.

Inform Prescribers and Patients that Gabapentin is Non-Formulary. In February 2011, CPHCS removed gabapentin from the drug formulary. Institution managers should educate patients about gabapentin's non-formulary status, and review the research findings regarding appropriate use of gabapentin with prescribers.

Review Prescribing Practices. In April 2011 via the Dashboard Scorecards, institutions will receive prescribing information for primary care providers which will include select pain medications. Once these prescribing profiles are released, review profiles with **individual providers** whose prescribing practices vary significantly from their peers.

Use Decision Support Tools to Promote Improvement. Multiple decision support tools were distributed to the field with the first Pain Management Report. These tools are available via SharePoint, along with latest exception reports and provider profiles. The following list of recommendations was proposed in the previous report, and once again, each institution is strongly encouraged to:

- Reinforce the importance of **Pain Care Guides** to Primary Care Teams. Make sure all primary care teams are familiar with Care Guide contents and have ready access to CareGuides at the point of care. Updated guidelines also should be available to inmates where appropriate.

- Reinforce training messages through local staff development activities. Use the **Quality of Care Review Tool** in provider self-assessments, staff evaluations by physician managers, and during weekly provider meetings, in the context of group case conferences.

Pain Management Committee. Current CPHCS pain care guidelines call for institutions to maintain a Pain Management Committee. Institution clinical leadership should review select pain management cases, complex patient cases, or cases where narcotics are being started or renewed for inmate-patients with chronic pain at the institution's Pain Management Committee and document decision-making. Use the Quality of Care Review Tool as a group to evaluate these cases, as appropriate. Institutions have been provided with a **template for Pain Management Committee documentation** that can be used to record findings.

Ongoing Local Monitoring. Several institutions that have shown improvements in pain care prescribing implemented an ongoing local monitoring program in partnership with pharmacy staff.

- Use local information sources and local quality improvement forums to monitor adherence to pain management guidelines, further analyze problems in pain care quality, and determine whether local interventions have resulted in improvements.
- Monitor pain treatment to improve consistency and identify impacts on other program areas. Conduct chart reviews and use local pharmacy data to assess guideline adherence and quality of care, including documentation quality.
- Many providers continue to prescribe medications that are used for acute pain to treat chronic pain. Monitoring Tramadol and Tylenol #3 prescriptions that exceed 30 days will help institution administrators to identify whether that is a quality problem at an institution, and using the Quality of Care Review Tool to review patients who have been prescribed these medications will help to determine whether the treatment provided is appropriate and well documented.
- Consider other program indicators in monitoring pain care improvements. This report monitors one dimension of pain care – prescribing of pain medications. There are other program areas or domains that might be monitored in conjunction with this report to provide a fuller picture of the quality of pain care, including, but not limited to:
 - Overdose cases
 - Inmate appeals
 - Access to clinical staff, medications, and specialty services
 - Overtime and registry usage for pharmacy and nursing staff

Discussion of Report Findings. Institution clinical leadership should **disseminate this report** broadly, and encourage discussion and action. Specifically, local leadership also should present the findings during routine meetings and assign ownership for specific follow-up tasks or improvement activities to each group; make meeting participants aware of the training and tools available to them.¹

¹ The Implementation Package affiliated with the Diabetes Clinical Outcomes Initiatives, disseminated in April 2010, includes a “Roles and Responsibilities” document that outlines the role of different meeting forums in supporting the Diabetes Clinical Outcomes Initiative and describes key tasks to be performed in each forum. The Implementation Package features a sample project management plan and sample agenda, meeting minutes, and action item lists. Institution executives can adapt these materials in organizing local quality management efforts to improve pain management.

Some of these routine **meeting forums** which focus on improving the quality of health care services include the Quality Management Committee, Pain Management Committee, Medical Program Subcommittee, Pharmacy and Therapeutics Committee, weekly provider meetings and daily primary care team meetings.

Patient Communication. Educating patients about pain guidelines and helping them understand the various lifestyle changes and interventions that mitigate acute and chronic pain may improve patient outcomes and may reduce the number of appeals filed when treatment plans are modified or medications are discontinued.

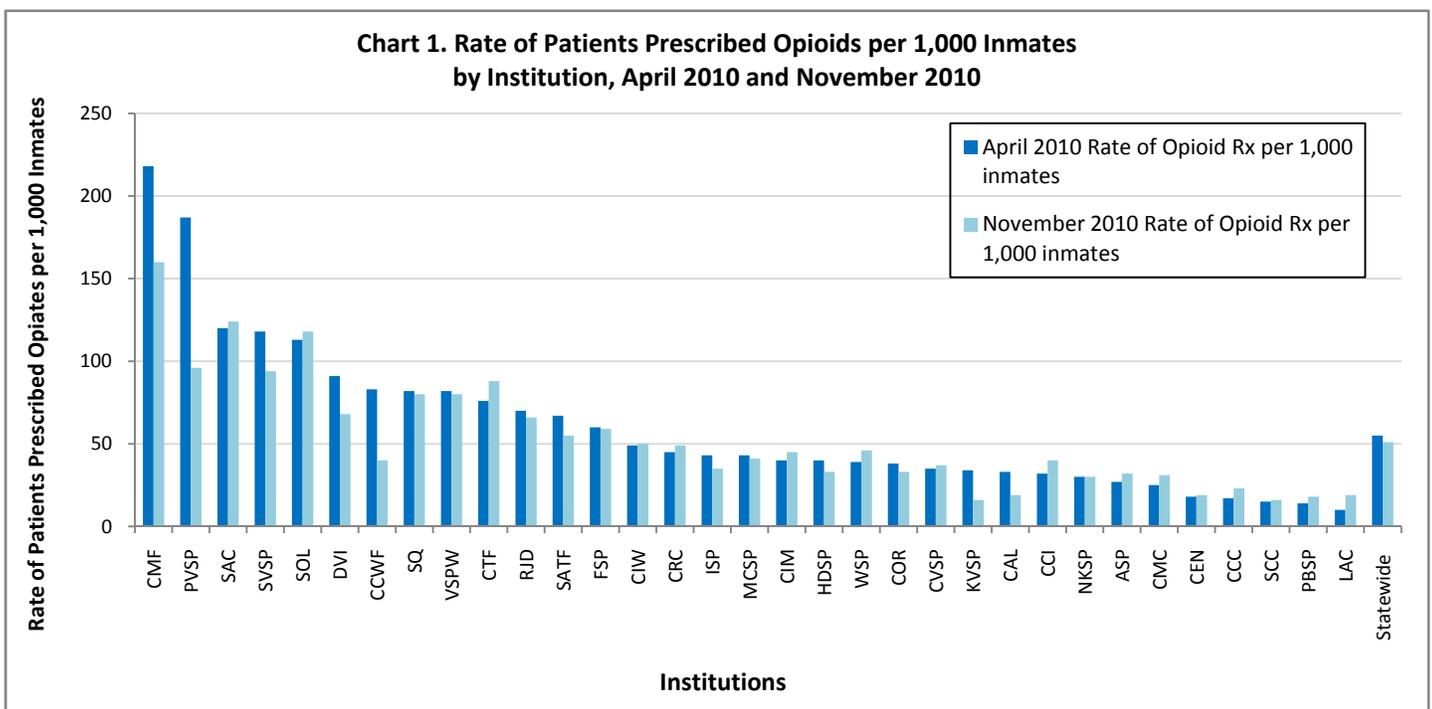
- Meet with the institution **Men's Advisory Council / Women's Advisory Council** or hold an information session in each housing unit to explain the new pain management guidelines, the benefits and disadvantages of certain medications, and the partnership between the patient and the Primary Care Team in improving personal health outcomes.
- Enlist the assistance of **peer educators** in educating patients about the new approach to pain management, particularly as it relates to patient self-management.
- Use the **CareGuide self-management materials** at the point of care to help patients identify and achieve treatment goals, and use **pain contracts** to clarify the patient's responsibilities in pain care.

Please see the following pages for detailed findings in each major pain medication category.

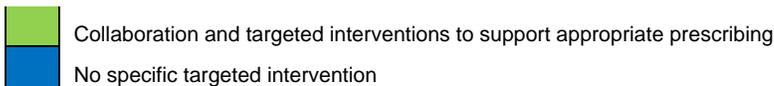
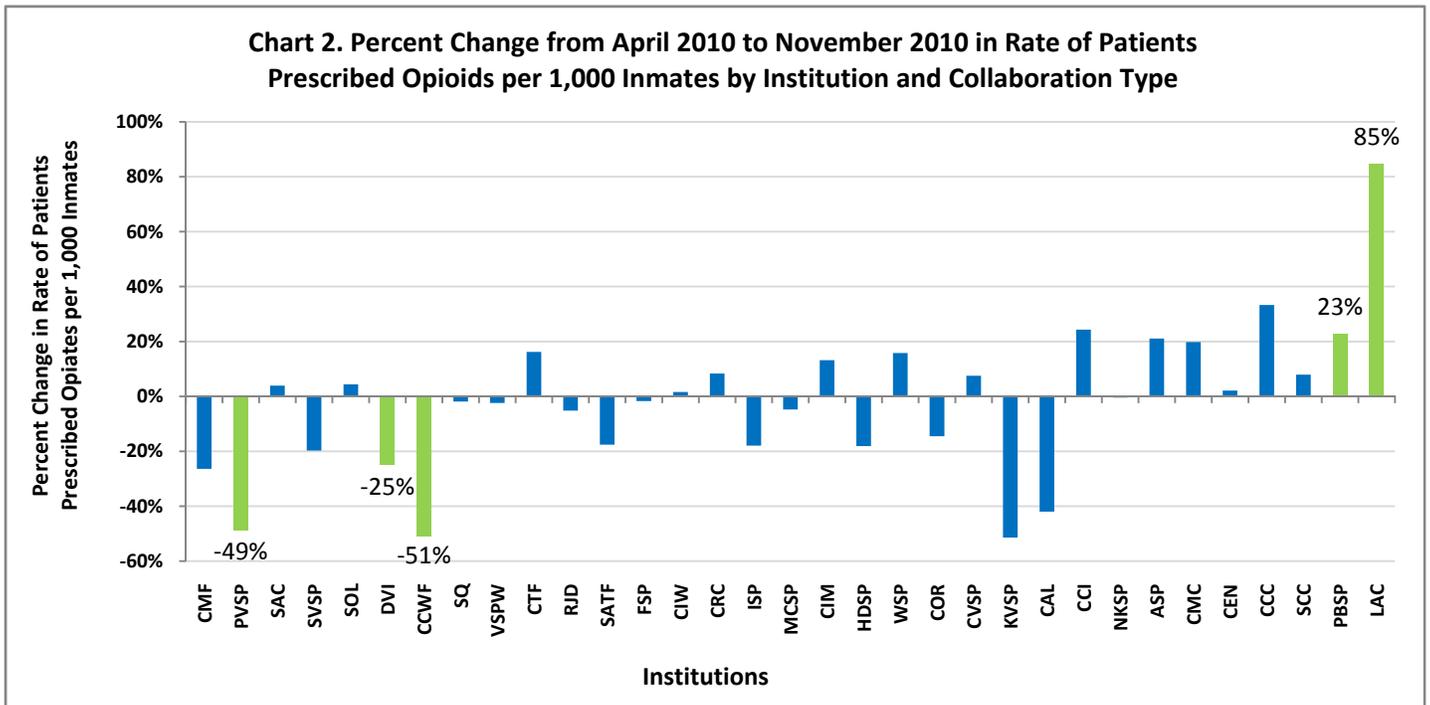
Opioids

In both April and November 2010, over 5 percent of inmates were prescribed one or more opioid pain medications (Chart 1 and Table 4).

- In April 2010, CCWF, CMF, DVI, PVSP, SAC, SOL and SVSP had opioid prescribing rates greater than 1.5 times the statewide average of 55 per 1000 inmates.
- Of these institutions, only SAC and SOL showed higher opioid prescribing rates in November than April; the other five institutions had lower rates.
- The rate of prescribing one or more opioid pain medications at CCC, CEN, LAC, PBSP and SCC remained less than half the statewide average, in November compared to April 2010.



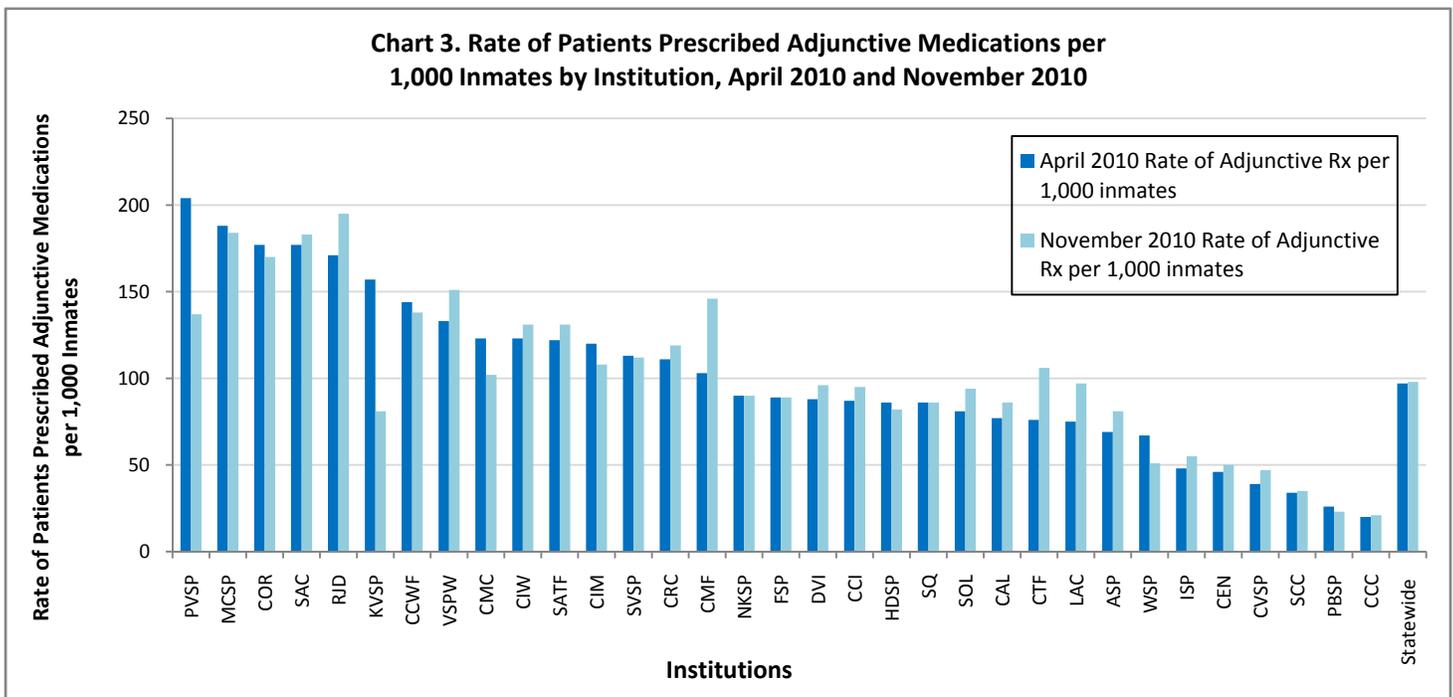
Some leaders from the institutions noted above collaborated closely with headquarters to review and modify the management of pain at their institutions. The three institutions with high prescribing rates in April 2010 that worked most closely with headquarters staff to improve pain care reduced their average rate by 41 percent, and two institutions with low rates of prescribing in a collaborative effort, increased their average rate by 54 percent (Chart 2).



Adjunctives

In both April and November 2010, almost 10 percent of inmate-patients had a prescription filled for one or more adjunctive medications, such as gabapentin (Chart 3 and Table 5).

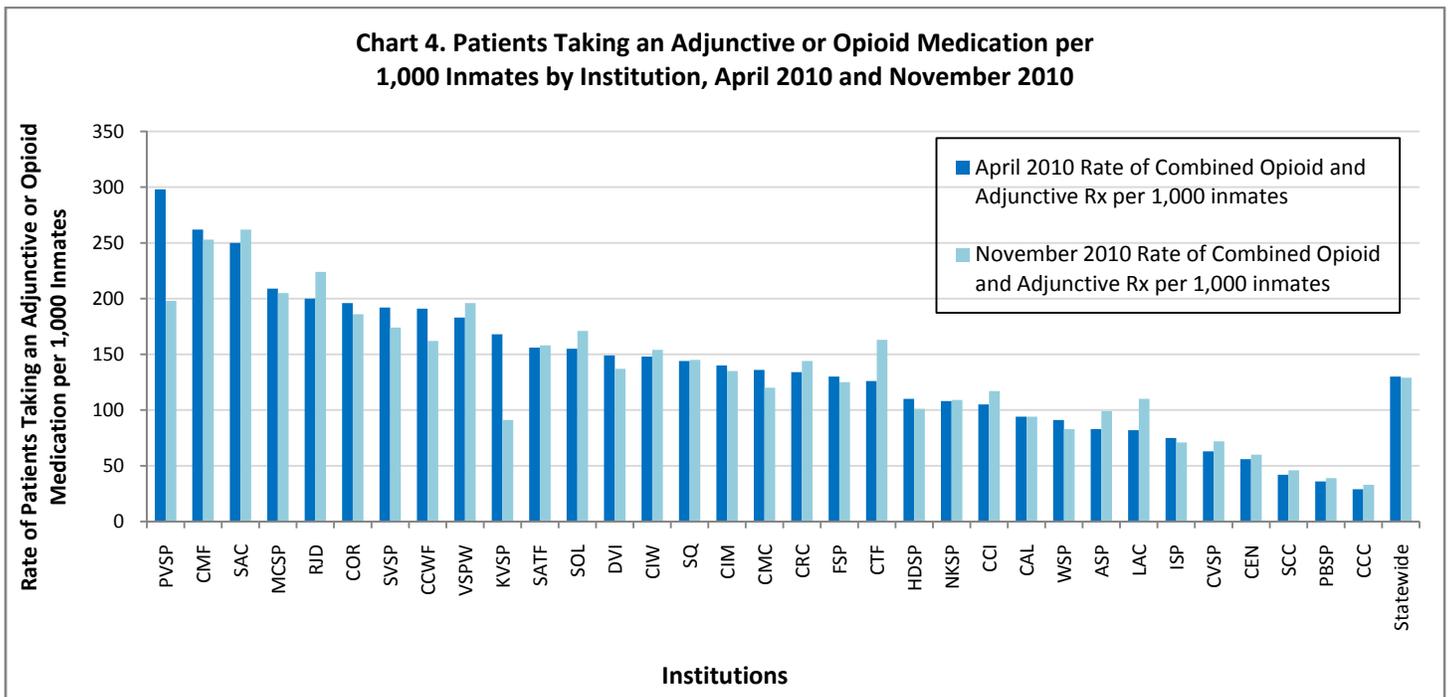
- COR, KVSP, MCSP, PVSP, RJD, and SAC had adjunctive medication prescribing rates greater than 1.5 times the April 2010 statewide average rate of 97 per 1000 inmates. Of these six institutions, COR, KVSP, MCSP and PVSP had lower rates in November 2010.
- KVSP, PVSP and WSP showed the largest reduction in prescribing of these medications, with a range of 25 percent to 49 percent reduction.
- On the other hand, over half of the institutions increased adjunctive prescribing rates from April to November 2010.



Opioid or Adjunctive Prescribing

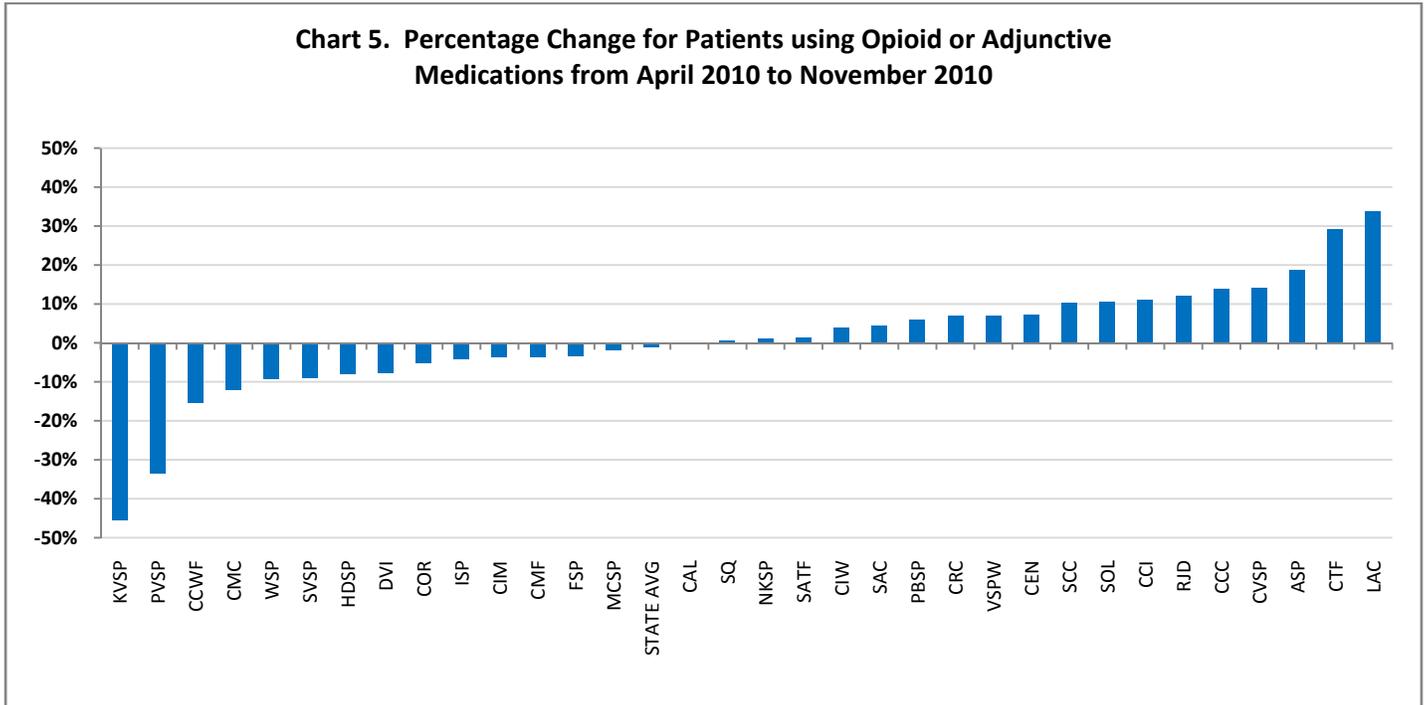
The number of patients per thousand on an opioid or adjunctive medication remained stable statewide between April 2010 and November 2010, but rates varied widely among institutions (Chart 4 and Table 6).

- In April 2010, CMF, MCSP, PVSP, RJD, and SAC had prescribing rates greater than 1.5 times the statewide average of 129 per 1000 inmates.
- Of these five institutions, CMF, MCSP and PVSP decreased their opioid or adjunctive prescribing rates in November, and RJD and SAC increased prescribing of opioid and/or adjunctive medications.



- CCWF, CMC, KVSP, and PVSP decreased prescribing of opioid or adjunctive medications by more than 10 percent, with KVSP having the largest decrease at 45 percent (Chart 5).
- CTF increased prescribing of opioid or adjunctive medications by 29 percent.
- Although ASP, CCC, CCI, CEN, CVSP, LAC and SCC increased prescribing rates of opioid and adjunctive medications, their prescribing rates remained below the statewide average.

Chart 5. Percentage Change for Patients using Opioid or Adjunctive Medications from April 2010 to November 2010



Seven institutions with a decrease in the number of patients taking opioids per thousand conversely showed an increase in the rate of patients taking an adjunctive medication (Table 2). Among these seven institutions, RJD had the highest percent increase at 12 percent. For another example, between April and November 2010, CMF decreased its opioid prescribing rate by 26 percent but increased its adjunctive prescribing rate by 42 percent resulting in only a 4 percent decrease overall for the combination of opioid and adjunctive prescribing.

Table 2.

Institutions with a Decrease in Opioid Prescribing Rate and Corresponding Increase in Adjunctive Prescribing Rate, April 2010 vs. November 2010

Institution	Opioid % Change, April 2010 vs. November 2010	Adjunctive % Change, April 2010 vs. November 2010	Overall % Change, April 2010 vs. November 2010
CAL	-42%	13%	0%
CMF	-26%	42%	-4%
DVI	-25%	9%	-8%
ISP	-18%	14%	-4%
SATF	-18%	7%	1%
RJD	-5%	14%	12%
VSPW	-2%	13%	7%

Excluding institutions whose prescribing rates were low for opioid and adjunctive medications (50 percent or less of the statewide average in April 2010), seven institutions showed an increase in both opioid prescribing and adjunctive prescribing rates. CTF showed the largest percent increase at 29 percent (Table 3).

Table 3.

Institutions with an Increase in Both Opioid and Adjunctive Prescribing Rates, April 2010 vs. November 2010

Institution	Opioid % Change, April 2010 vs. November 2010	Adjunctive % Change, April 2010 vs. November 2010	Overall % Change, April 2010 vs. November 2010
CCI	24%	9%	11%
CTF	16%	39%	29%
CVSP	8%	19%	14%
CRC	8%	8%	7%
SOL	4%	17%	10%
SAC	4%	4%	5%
CIW	2%	7%	4%

Appendix

Table 4
Opioid Medication Prescribing Table

Opioid Prescription Rates, Number of Patients Prescribed Opioids and Percent Change in Rate from April 2010 to November 2010					
Institution	Opioid Prescriptions per 1,000 Inmates April 2010	Opioid Prescriptions per 1,000 Inmates Nov 2010	Number of Patients Prescribed Opioid Medications April 2010	Number of Patients Prescribed Opioid Medications Nov 2010	Percent Change in Opioid Prescription Rates per 1000 Inmates from April to Nov 2010
ASP	27	32	167	191	21%
CAL	33	19	138	78	-42%
CCC	17	23	94	123	33%
CCI	32	40	191	230	24%
CCWF	83	40	309	151	-51%
CEN	18	19	82	74	2%
CIM	40	45	201	250	13%
CIW	49	50	123	111	2%
CMC	25	31	163	184	20%
CMF	218	160	574	409	-26%
COR	38	33	203	163	-15%
CRC	45	49	196	206	8%
CTF	76	88	484	571	16%
CVSP	35	37	121	114	8%
DVI	91	68	350	261	-25%
FSP	60	59	222	203	-2%
HDSP	40	33	180	140	-18%
ISP	43	35	176	139	-18%
KVSP	34	16	162	77	-51%
LAC	10	19	48	87	85%
MCSP	43	41	162	146	-5%
NKSP	30	30	161	159	0%
PBSP	14	18	48	57	23%
PVSP	187	96	881	442	-49%
RJD	70	66	320	294	-5%
SAC	120	124	348	364	4%
SATF	67	55	440	350	-18%
SCC	15	16	83	88	8%
SOL	113	118	574	588	4%
SQ	82	80	400	405	-2%
SVSP	118	94	443	352	-20%
VSPW	82	80	288	278	-2%
WSP	39	46	239	262	16%
Statewide	55	51	8388	7475	8%

Table 5
Adjunctive Medication Prescribing Table

Adjunctive Prescription Rates, Number of Patients Prescribed Adjunctive Medications and Percent Change in Adjunctive Prescription Rates from April 2010 to November 2010					
Institution	Adjunctive Prescriptions per 1,000 Inmates April 2010	Adjunctive Prescriptions per 1,000 Inmates Nov 2010	Number of Patients Prescribed Adjunctive Medications April 2010	Number of Patients Prescribed Adjunctive Medications Nov 2010	Percent Change in Adjunctive Prescription Rates per 1000 Inmates from April to Nov 2010
ASP	69	81	435	479	17%
CAL	77	86	321	352	13%
CCC	20	21	109	112	5%
CCI	87	95	518	545	9%
CCWF	144	138	540	514	-5%
CEN	46	50	206	198	9%
CIM	120	108	601	595	-10%
CIW	123	131	310	294	7%
CMC	123	102	784	617	-17%
CMF	103	146	271	372	42%
COR	177	170	943	849	-4%
CRC	111	119	482	503	8%
CTF	76	106	484	684	39%
CVSP	39	47	138	144	19%
DVI	88	96	339	367	9%
FSP	89	89	332	308	0%
HDSP	86	82	387	348	-5%
ISP	48	55	195	214	14%
KVSP	157	81	753	378	-49%
LAC	75	97	343	435	29%
MCSP	188	184	704	652	-2%
NKSP	90	90	486	479	-1%
PBSP	26	23	86	73	-12%
PVSP	204	137	957	629	-33%
RJD	171	195	786	869	14%
SAC	177	183	514	536	4%
SATF	122	131	799	828	7%
SCC	34	35	184	188	4%
SOL	81	94	410	470	17%
SQ	86	86	420	434	0%
SVSP	113	112	427	418	-1%
VSPW	133	151	470	526	13%
WSP	67	51	408	291	-25%
Statewide	97	98	14755	14453	1%

Table 6
Opioid or Adjunctive Medication Prescribing Table

Opioid or Adjunctive Prescription Rates, Number of Patients Prescribed Opioid or Adjunctive Medications and Percent Change in Rate from April 2010 to November 2010					
Institution	Opioid or Adjunctive Prescriptions per 1,000 Inmates April 2010	Opioid or Adjunctive Prescriptions per 1,000 Inmates Nov 2010	Number of Patients Prescribed Opioid or Adjunctive Medications April 2010	Number of Patients Prescribed Opioid or Adjunctive Medications Nov 2010	Percent Change in Opioid or Adjunctive Prescription Rates per 1000 Inmates from April to Nov 2010
ASP	83	99	524	588	19%
CAL	94	94	394	384	0%
CCC	29	33	159	178	14%
CCI	105	117	624	672	11%
CCWF	191	162	715	604	-15%
CEN	56	60	252	239	7%
CIM	140	135	706	748	-4%
CIW	148	154	373	344	4%
CMC	136	120	872	722	-12%
CMF	262	253	691	645	-4%
COR	196	186	1044	929	-5%
CRC	134	144	583	605	7%
CTF	126	163	805	1056	29%
CVSP	63	72	221	221	14%
DVI	149	137	574	526	-8%
FSP	130	125	482	433	-3%
HDSP	110	101	492	430	-8%
ISP	75	71	304	280	-4%
KVSP	168	91	802	428	-45%
LAC	82	110	376	494	34%
MCSP	209	205	779	724	-2%
NKSP	108	109	581	583	1%
PBSP	36	39	122	125	6%
PVSP	298	198	1401	908	-34%
RJD	200	224	919	999	12%
SAC	250	262	728	766	5%
SATF	156	158	1021	999	1%
SCC	42	46	228	247	10%
SOL	155	171	788	855	10%
SQ	144	145	703	729	1%
SVSP	192	174	723	651	-9%
VSPW	183	196	644	682	7%
WSP	91	83	552	474	-9%
Statewide	130	129	19690	18959	-1%

Table 7

Institution Abbreviations

ASP	Avenal State Prison
CAL	Calipatria State Prison
CCC	California Correctional Center
CCI	California Correctional Institution
CCWF	Central California Women's Facility
CEN	Centinela State Prison
CIM	California Institution for Men
CIW	California Institution for Women
CMC	California Men's Colony
CMF	California Medical Facility
COR	California State Prison, Corcoran
CRC	California Rehabilitation Center
CTF	Correctional Training Facility
CVSP	Chuckawalla Valley State Prison
DVI	Deuel Vocational Institution
FSP	Folsom State Prison
HDSP	High Desert State Prison
ISP	Ironwood State Prison
KVSP	Kern Valley State Prison
LAC	California State Prison, Los Angeles County
MCSP	Mule Creek State Prison
NKSP	North Kern State Prison
PBSP	Pelican Bay State Prison
PVSP	Pleasant Valley State Prison
RJD	Richard J. Donovan Correctional Facility
SAC	California State Prison, Sacramento
SATF	California Substance Abuse Treatment Facility & State Prison at Corcoran
SCC	Sierra Conservation Center
SOL	California State Prison, Solano
SQ	California State Prison, San Quentin
SVSP	Salinas Valley State Prison
VSPW	Valley State Prison for Women
WSP	Wasco State Prison