Coalition for Physician Enhancement Webinar #4
June 13, 2017
11 AM Eastern Daylight Time

Physician Opioid Prescribing
Understanding, Identifying, and Remediating Problematic Behaviors

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Mara McErlean, MD – Albany Medical College
Rob Steele, MD – Texas A&M University College of Medicine

Webinar Process

- There will be up to 100 participants in this webinar today.
- Sound will be muted on the presenter's side: you'll hear us, but we won't hear you (to limit background noise/feedback).
- Questions will be taken at the end of the webinar – **please type them in under the Questions tab.**
- Presentation – 45 minutes
- Q&A – 15 minutes

Physician Opioid Prescribing
Understanding, Identifying, and Remediating Problematic Behaviors

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- **Course Director:** Rob Steele, M.D.
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- **Webinar Hosted in-kind by:** KSTAR Program, Rural and Community Health Institute (RCHI), Texas A&M University College of Medicine

Disclosure

Faculty Disclosure: CPE Webinar – Physician Opioid Prescribing: Understanding, Identifying, and Remediating Problematic Behaviors

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The following faculty and planning committee members have stated that they do not have any relationships to disclose :

Dave Bazzo, MD; Mara McErlean, MD; William Norcross, MD; Henry Pohl, MD; Mark Staz, MA; Rob Steele, MD; and Bree Watzak, PharmD

Coalition for Physician Enhancement (CPE)

A consortium of professionals with expertise in quality assurance, medical education, and the assessment, licensing, and accreditation of referred physicians seeking higher levels of performance in patient care.

CPE: The Mission and Vision

- **Mission:** *To support and develop expertise in assessment and education for physicians and other healthcare providers who seek a higher level of performance.*
- **Vision:** *CPE will be a leader in the development of a system that fosters safe practice and enhanced performance by physicians and other healthcare providers in North America*

SAVE THE DATE!
The Next Coalition for Physician Enhancement Meeting
October 26-27, 2017

Physician Assessment Tool Kit: Exploring Time-Honored and Novel Approaches to Using Medical Charts

Hosted by CPEP – The Center for Personalized Education for Physicians
Denver, Colorado

THIS MEETING WILL BE FOR CPE MEMBERS ONLY – CONSIDER JOINING CPE!

For more information:
www.cpe.memberlodge.org

Learning Objectives

- At the end of this presentation participants will be able to:
  - Discuss historical influences on physician opioid prescribing patterns
  - Review the current landscape of opioid prescribing and regulation
  - Identify the most commonly encountered problematic prescribing behaviors that are associated with discipline
  - List the characteristics of physicians who over-prescribe opioids
  - Discuss current approaches to identifying and remediating problematic prescribing behaviors

History of Opioid Use and Prescribing

- History of Pain
  - Perception of pain by physicians and society
  - Historical options for pain management
- Emergence of prescription medications
  - Specific attention to opioid pain relief
- Factors influencing use of opioid medications
  - Societal
  - Medical
  - Regulatory

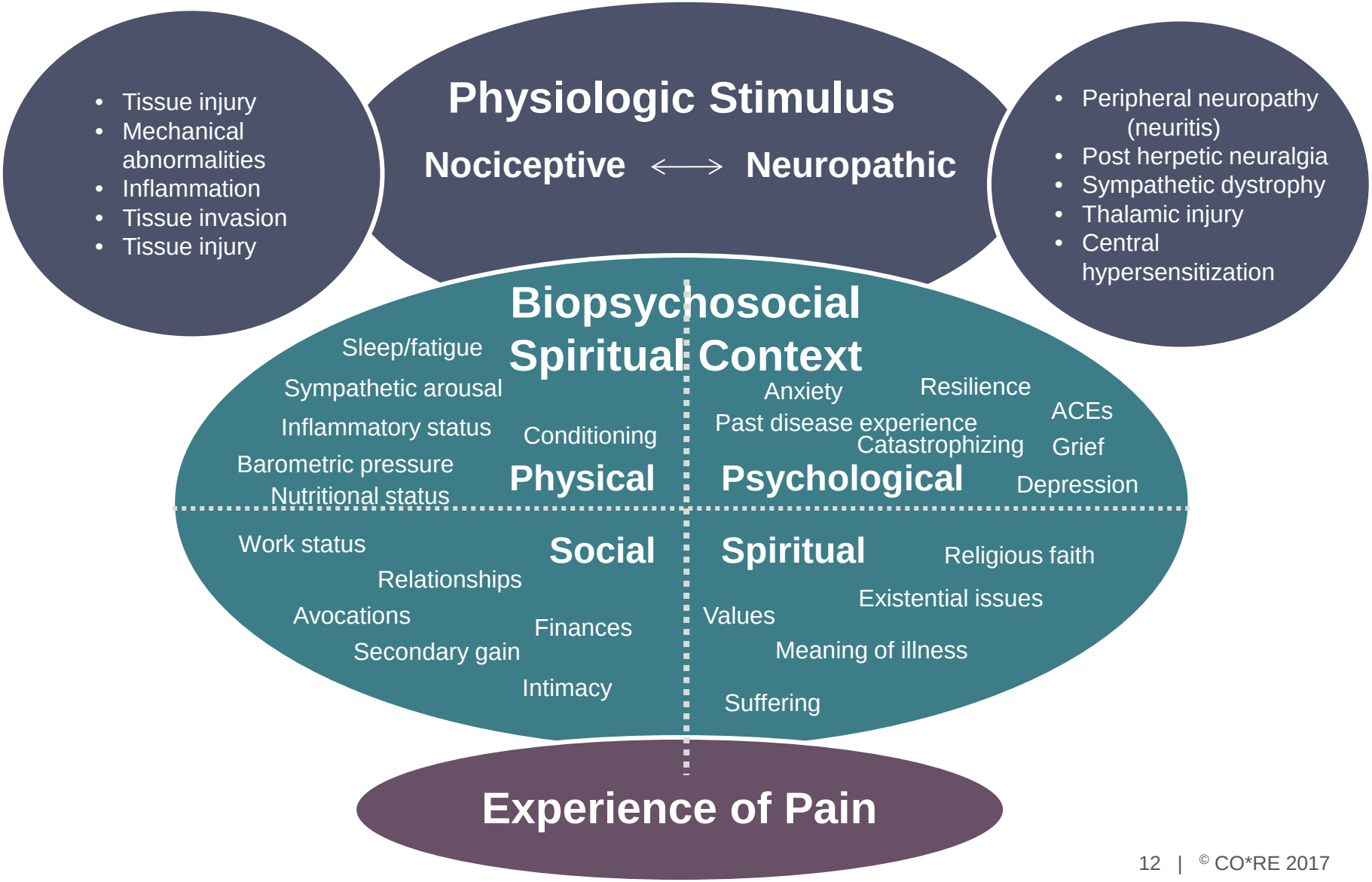
What is pain and why do we have it?

- Physical sensation
- Protective
- Elicits a behavioral response
- Helps avoid further or repeat injury

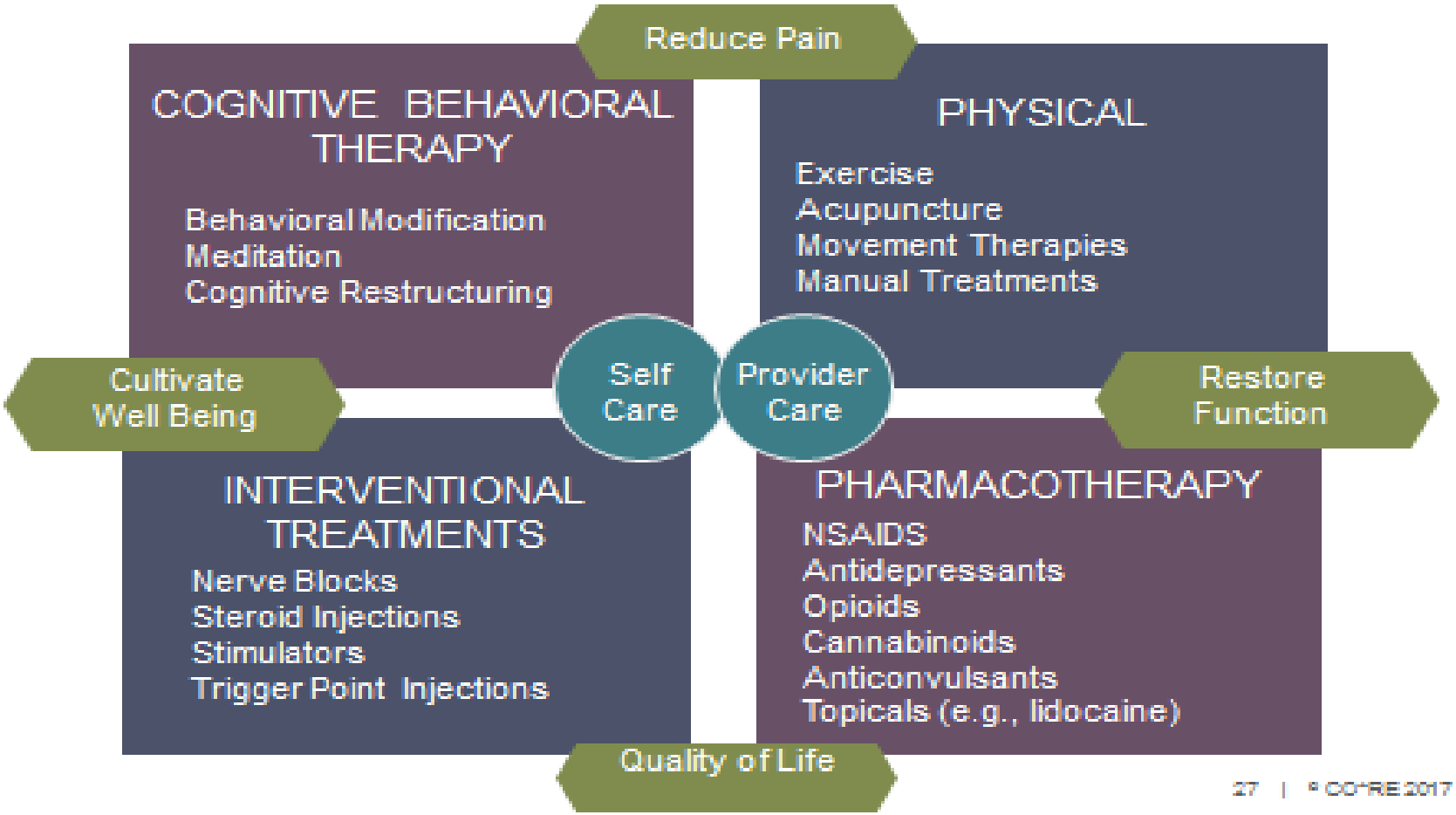
Perceptions of Pain

- “Pain is the oldest medical problem”
- “Universal affliction of mankind”
- Physicians used it as a necessary marker for disease
- Pain that didn’t resolve heralded death
- Chronic pain to be borne
- Maybe it is even good for you……

UNDERSTANDING PAIN



PAIN MANAGEMENT GOALS AND TREATMENT OPTIONS: A MULTI-MODAL APPROACH



Opium

- 3400 BC, first used in Mesopotamia
- Spread around Middle East, Far East, Europe
- Often mixed with alcohol (Sydenham mixed with sherry, 1680)
- Smoked by some, this more addictive
- Contains morphine, codeine, thebaine and papaverine

Opium Use

- No regulation when introduced in the US
- Was often used in proprietary preparations
- Use escalated greatly after the Civil War
  - Veterans with injuries suffered long-term pain
  - No good therapies available
  - Veterans revered, caused physicians to evaluate the cause of pain more, seek to relieve
  - Source of chronic pain unclear, but also undeniable

Later 1800s

- Opiates standard for treatment of acute pain
- 1804 FW Surturner synthesized morphine
- 1820 able to produce in industrial quantity
- 1855 hollow needle and syringe was invented
  - MDs happy to distinguish themselves
- 1898 di-acetylated morphine was created by Bayer pharmaceuticals= heroin

Other emerging ways to relieve pain

- 1846 – Ether first used to induce anesthesia
- 1848 – Chloroform first used

- Allowed longer, more complex surgeries
- Began a concept that pain relief was beneficial even if it only allowed a surgical cure

1900s

- Heroin introduced (1898) then banned (1924)
- Aspirin introduced- first non-narcotic oral treatment available (1917)

- Efforts to separate analgesia from addiction
- Interest in pain management during and after WW II
- Attempt to understand affective and cognitive components of pain

Later 1900s

- Increasing interest in pain relief
  - Oxycodone, hydrocodone introduced in late 1970s
- 1980 – short letter in JAMA of nearly 12,000 treated with narcotics: addiction "rare"
- 1987 – IOM advocated quantifying pain based on patient assessment
- 1990 – "The Clarion Call for a Different Approach to Improve Assessment and Treatment of Pain" *Annals of Internal Med*

Late 1990s

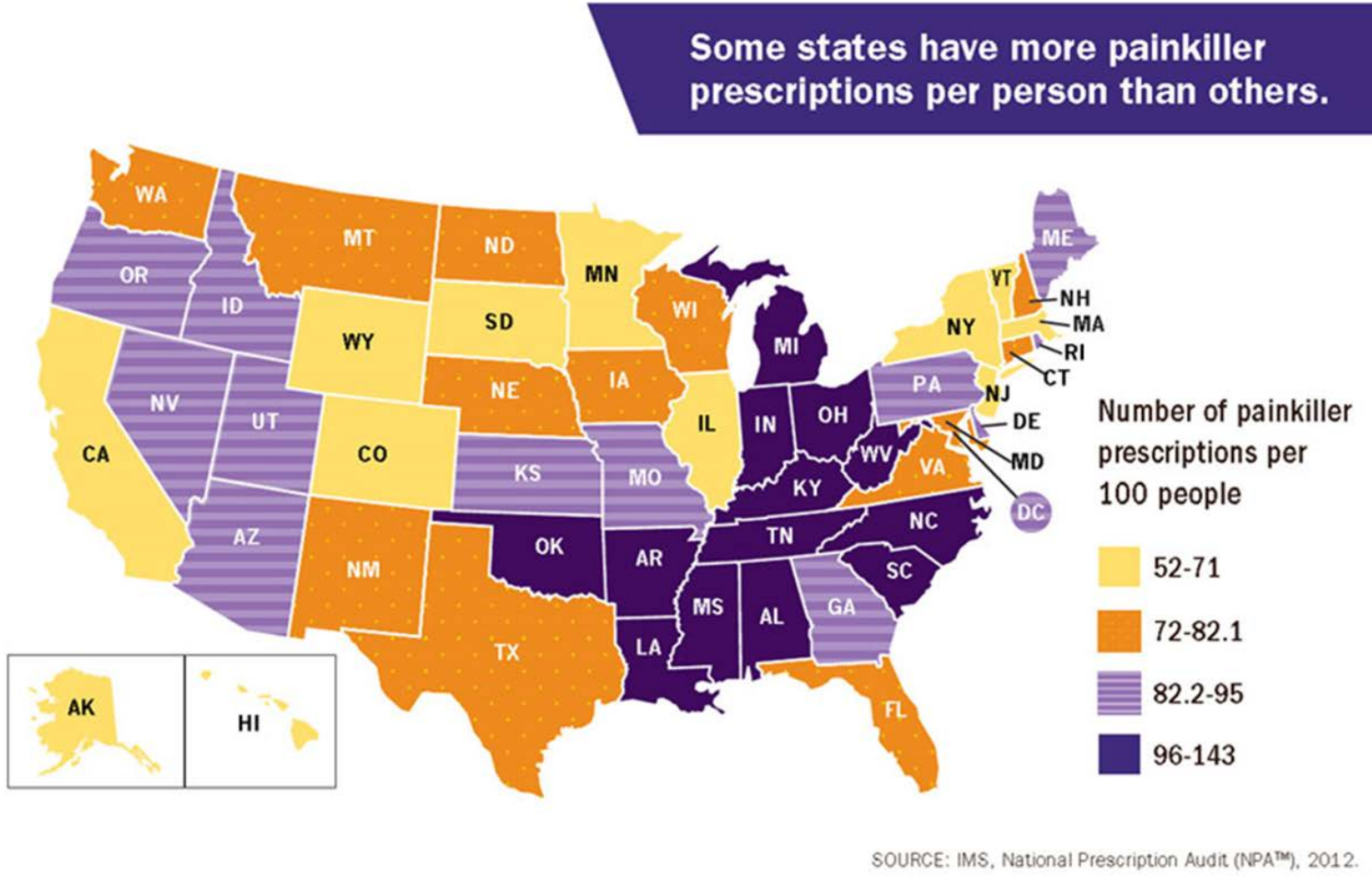
- 1997 – Standard to assess pain in PACUs
- Studies: inadequate acute pain control
- Studies: providers underestimate pain
- Studies: disparities in treatment associated with age, gender, race and ethnicity

- Pain assessment called the “5th Vital Sign”
- 1999 – CA Assembly Bill 791: “Every health facility….include pain as an item to be assessed at the same time as vital signs are taken.”

And marketing….

- 1996 – Sustained release oxycontin released
- 1998 – Purdue Pharma marketing campaign “I Got My Life Back”– print and video
- MD endorsements widespread
- 2000 Book published for Joint Commission says “no evidence that addiction is a significant issue”
- 2001 – JC releases standards
  - Institutions needed systematic approach and quantitative measures to address pain

Prescription writing



SOURCE: IMS, National Prescription Audit (NPA™), 2012.

And although US has highest per capita use of opioids…….

- Canada ranks second
- Similar issues with overprescribing
- Not equally distributed across provinces
- Not equally distributed between social and economic classes
- Attempts to address both national and provincial
- Similar problems with high rates addiction and lack of services leading to emphasis on prevention

How Problematic Controlled Substance Prescribing Is Identified

Many ways, including:

- **Complaints to a medical board (standard of care)**
  -complaints directly related to prescribing
  -found incidentally when investigating other concerns
- **Complaints and concerns from pharmacies/pharmacists**
- **Prescription Monitoring Programs (now multi-state!)**
- **Third party payers (CMS, insurance companies)**
- **Specific surveillance programs (Example: "Houston Cocktail")**
- **Probably more** – every state has their own approach

Medical Board Complaints Example: Texas

- Often from patients, their families, friends
- Can be anonymous
- Usually allege that the standard of care of was not met
- Investigations almost always involve reviewing the medical records that pertain to a given case
- May be initially related to prescribing, but "non-therapeutic" prescribing is often discovered incidentally when an unrelated complaint is being investigated based when documentation is being reviewed
- Note: The Texas Medical Board **notifies physicians when they are being investigated**; other states may not

Complaints from Pharmacies/Pharmacists

When concerns are raised about opioid prescribing, pharmacists can:

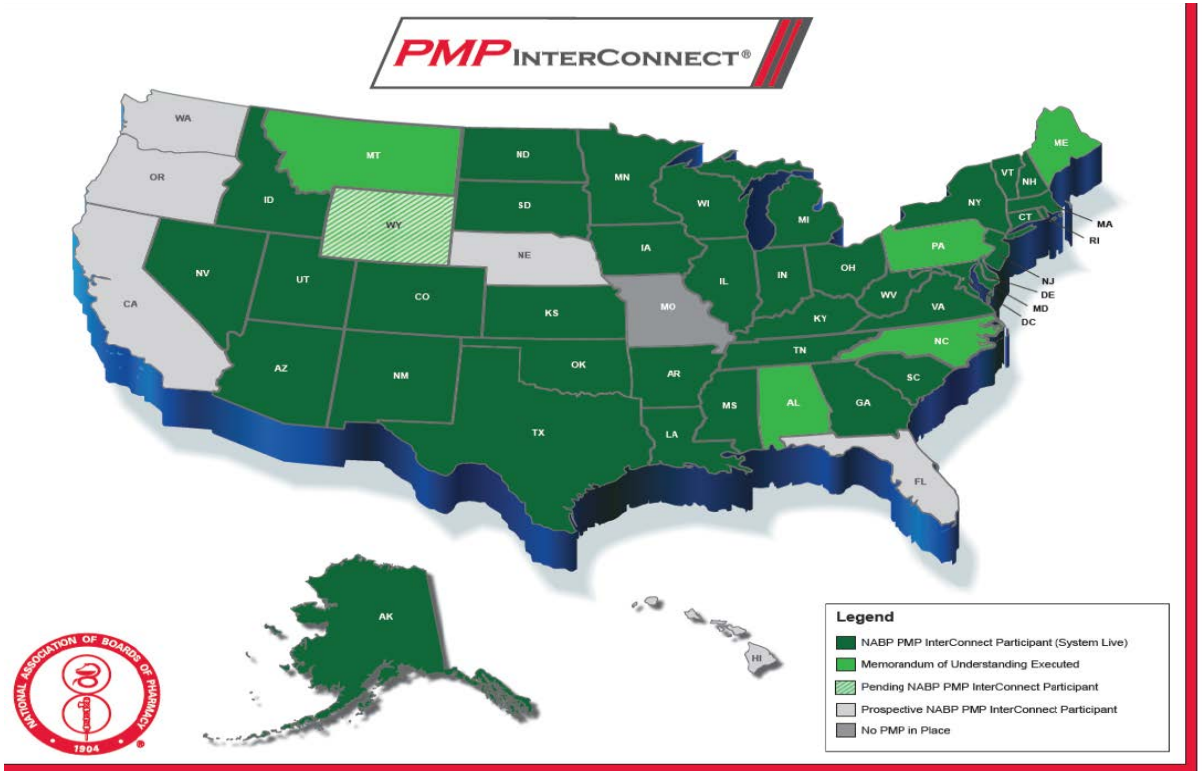
- Alert the providers writing the script
- Contact the DEA Drug Diversion Hotline
  1-877-RxAbuse
- Report concerns to respective Medical Board
- Report to respective State Board of Pharmacy
- Contact local Narcotics Task Force

Prescription Monitoring

- State and Interstate Monitoring Programs
- Medicare/OIG Hotline: 1-800-HHS-TIPS
- **Surveillance/feedback from a physician's own hospital or medical group**
- **Insurance Companies: Example – Cigna**
  - Cues the practitioner to review prescribing
  - Can limit where the patient pick up Rx
  - Can limit which doctors prescribe narcotics to specific patients

38 States Now Participate in the PMP InterConnect Program

https://nabp.pharmacy/wp-content/uploads/2017/03/PMPMap_3-29-17_large.png
Accessed 5/25/2017

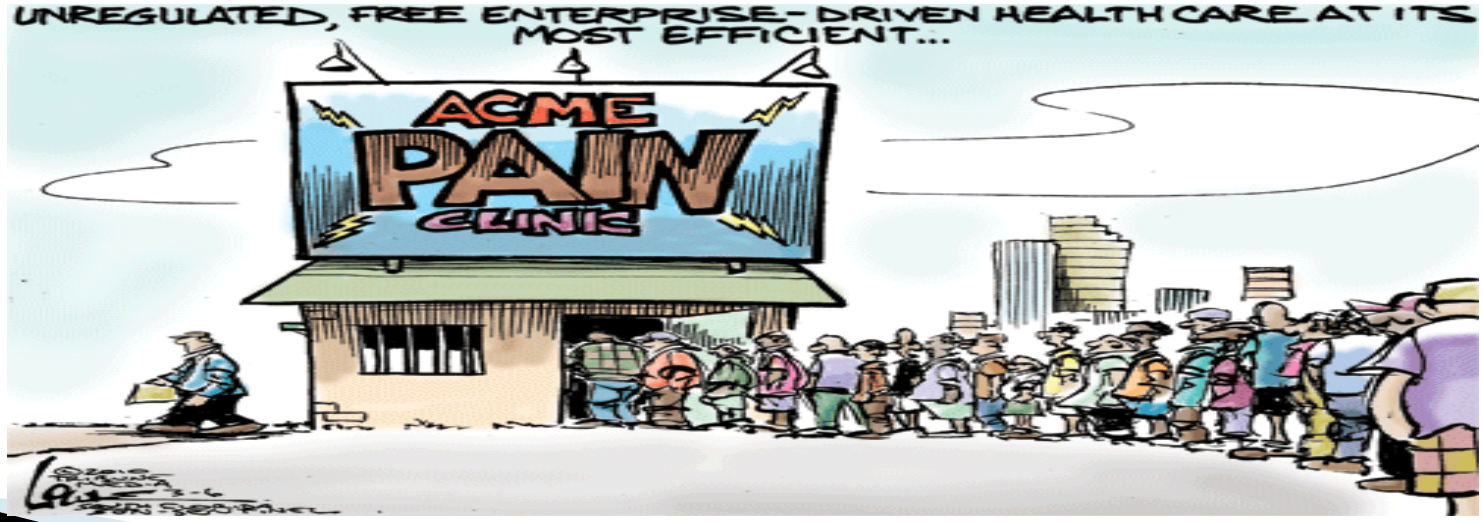


Specific Surveillance Programs Example: The "Houston Cocktail"

- Refers to: hydrocodone, alprazolam, and carisoprodol (Soma)—when taken together, they cause a "high" similar to heroin
- This combination was frequently sought by drug-seeking patients and **was often prescribed at pill-mills**
- Monitoring that combination of medications by the Texas Dept of Public Safety and the Texas State Board of Pharmacy has allowed specific physicians and entire clinics to be identified
- Specific active monitoring is not routinely done for all controlled substances

Patient Behaviors at Clinics and Pharmacies

- Patient lines around the corner at a run-down medical clinic that does pain management….
- Vans dropping off loads of patients….
- Cash-only service…
- Pharmacies getting 25+ scripts/hour near a clinic that could not possible see that many patients in an hour..



Who's Writing Those Scripts?

Physicians Found Overprescribing Often Fall Into These Categories: One-Size-Fits-All Will Likely NOT work…

- **Dated**: out of date regarding knowledge of pharmacology and the differential diagnosis and management of chronic pain
- **Duped**: physician may be duped by patients; vulnerability to manipulative/dishonest patients
- **Dishonest**: thankfully uncommon; writing prescriptions in exchange for financial gain (pill mill doctors)
- **Disabled**: "loose" prescribers with medical or psychiatric disabilities (chemical dependency or personality disorders); less likely to confront patients out of fear of turning suspicion on themselves

Longo L, Parran T, Johnson B, Kinsey W. Addiction: Part II. Identification and Management of the Drug-Seeking Patient. Am Fam Physician. 2000 Apr 15;61(8):2401-2408.

Ways to Impact MD Behavior

- Regulatory checks work- lower rates seen in states who ***require*** MDs to check prescribing history
- Shared information helps- especially with addictive behaviors and MD shopping
- Education is useful but likely not sufficient

- **Beware of opioid overprescribing as a marker for other deficiencies in care provision**

How can we manage risk

- Require prescribing CME
  - CA AB 487 – started as a result of under treating pain
    - Became law 2001 – 12 units CME in pain and palliation
- Prescribing courses for disciplined physicians
  - Offered by assessment programs and CME providers
  - Don't get many voluntary attendees
  - How can we measure success
    - Some offer pre-post tests
    - Look at recidivism rates

THE FEDERAL PLAYERS

Many agencies involved

FDA

SURGEON GENERAL .GOV

CDC

Office of National Drug Control Policy

NIH National Institute on Drug Abuse
The Science of Drug Abuse & Addiction

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Federation of STATE MEDICAL BOARDS

Changes in assessing pain

- Pain as the 5th Vital Sign is no longer measured on a 10 point or visual analog scale
- Look at function, activities, ADLs
- Monitor for aberrant behavior
- Use other modalities for treatment
- Co-prescribing Naloxone
- Maximum morphine equivalents (50, 90, 100)
- Availability of treatment centers and funding

Opioid Epidemic

- FDA – REMS – Blueprint for ER/LA opioids 2012

https://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM515636.pdf

  - Educational offerings to improve safe prescribing
  - Measure "completers"
- CDC Guidelines https://www.cdc.gov/drugoverdose/prescribing/providers.html
  - Cancer pain, hospice and palliative care patients are not covered by CDC Guideline
- State Medical Board prescribing guidelines and laws
  - Evaluation
  - PDMP
  - Toxicology screen
  - Limiting quantities

Medical Cannabis-Controversy

Medical Cannabis

- DEA Schedule 1
- More research is needed
- There is good evidence that cannabis or selective cannabinoids (cannabidiol) are effective for chronic pain treatment in adults
- Use available scientific evidence, advise patients
- Inform about potential effects; AEs mostly mild and well tolerated (cough, anxiety)
- Screen for potential misuse/abuse, diversion
- Set treatment goals, use PPA
- Encourage patients to keep notes, discuss with them
- Document everything
- Regular re-evaluation
- Consider periodic UDTs
- Discontinue if not helpful moving toward goals
- Edibles are the fastest growing delivery system
- No well controlled studies on the combined use of opioids and cannabis

SOURCE: The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research. A National Academy of Science publication (2017)

Conclusions

- Multiple factors have contributed to overprescribing of narcotics
- Reasons for problem prescribing varies and can be multi-factorial
- Regulatory intervention seems to work well
- Solutions to address will need to be individualized to some extent- education alone likely insufficient
- Problem opioid prescribing may not be isolated problem in physician performance

Questions?

Please type them in! We'll answer as many as time allows.

This webinar has been recorded and will be available (along with our slides) on our website: www.cpememberlodge.org

CPE Events and Membership!

We present two educational conferences each year.

Coming next:

October 26-27, 2017 (Denver), hosted by CPEP

Physician Assessment Tool Kit:
Exploring Time-Honored and Novel Approaches to Using Medical Charts

May 3-4, 2018, (Toronto), hosted by the College of Physicians and Surgeons of Ontario (CPSO) – topic to be announced soon!

For more information: www.cpe.memberlodge.org

CPE Events and Membership

- CPE presents several webinars each year on topics that pertain to our mission, vision, and the interests of other stakeholders
- Interested in becoming a member of CPE? We have individual and organizational memberships
- You don't have to a member to attend our spring meetings; are fall meetings are more specific to CPE and do require membership in our organization

For more information: www.cpe.memberlodge.org