Responding to the Opioid Morbidity and Mortality

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Deputy Director
National Institute on Drug Abuse

NIH National Institute on Drug Abuse
Science = Solutions
Marked Geographic Variation in Mortality: Estimated Age-adjusted OD Death Rates, by County, 2014

Overlap of **Benzodiazepines and Opioids**

Opioid Analgesic ED Visits and OD Deaths Involving Benzodiazepines & Benzodiazepine ED Visits and OD Deaths Involving Opioids

Abuse of Rx Opioids has led to a Rise in **Heroin Abuse and Associated Deaths** from Overdoses

Past Month & Past Year Heroin Use Persons Aged 12 or Older

<table>
<thead>
<tr>
<th>Year</th>
<th>Past Month</th>
<th>Past Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>404</td>
<td>166</td>
</tr>
<tr>
<td>2006</td>
<td>398</td>
<td>119</td>
</tr>
<tr>
<td>2010</td>
<td>560</td>
<td>455</td>
</tr>
<tr>
<td>2014</td>
<td>582</td>
<td>669</td>
</tr>
</tbody>
</table>

**Thousands**

Heroin Overdose Deaths

<table>
<thead>
<tr>
<th>Year</th>
<th>Heroin Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>1,960</td>
</tr>
<tr>
<td>2004</td>
<td>1,842</td>
</tr>
<tr>
<td>2009</td>
<td>5,925</td>
</tr>
<tr>
<td>2014</td>
<td>10,574</td>
</tr>
</tbody>
</table>

SAMHSA, National Survey on Drug Use and Health.

CDC/NCHS, National Vital Statistics System, Mortality File
A Shift From Abuse of Prescription Pain Relievers to Heroin

Growing evidence suggests a shift to heroin among patients entering treatment for an opioid use disorder: Increase in heroin use accompanied a downward trend in OxyContin abuse following introduction of abuse-deterrent formulation.
Most Heroin Users Report *Previous Non-Medical Use* of Prescription Opioids,

BUT Only a *Small Proportion of Non-Medical Users Progress to Heroin*

### National General Population:
- Within 5 years, 3.6% of non-medical users of opioids progressed to heroin within 5 years (i.e. less than 1% per year)  
  *(Muhuri, Gfroerer, Davies. 2013)*

### Local Longitudinal Study of Non-medical users:
- Within 3 years, 7.5% progressed to heroin (i.e. 2.8% per year)  
  *(Carlson, Nahhas, martins, Daniulaityte. 2015)*
Increases in All Regions, Especially Northeast and Midwest: Age-Adjusted Rates for Heroin Drug-Poisoning Deaths

Deaths per 100,000 population

2000  2007  2013

Northeast  Midwest  South  West

CDC, NCHS Data Brief, No 190, March 2015.

Increases for All, Especially Non-Hispanic Whites: Heroin Drug-Poisoning Deaths by Subgroups

Deaths per 100,000 population

2000  2013

Northeast    Midwest    South    West

CDC, NCHS Data Brief, No 190, March 2015.
35 States reported analyzing fentanyl during the first half of 2009. No States had more than 49 fentanyl reports. Two States had between 20 and 49 reports.

In the first half of 2014, 46 States reported fentanyl, including 6 with 100 or more reports and 5 States between 50 and 99. Highest numbers mainly in Midwest and Northeast.
HHS Opioid Priority Areas

- Opioid *prescribing practices* to prevent opioid use disorders and overdose
- The expanded use of *naloxone*, used to treat opioid overdoses
- Expanded use of *medication assisted treatment* (MAT) for opioid use disorders

*Launched by Secretary Burwell March 2015*

[Link to report](http://aspe.hhs.gov/sp/reports/2015/OpioidInitiative/es_OpioidInitiative.pdf)
Selected Themes:

• **Indiana HIV Outbreak**
• **Medication Assisted Treatments**: Expanding Reach of Essential Services
• **Naloxone for Overdose Treatment**: First Responder and Other Points of Access
• **Prescribing Practices**: Policy and Practice Interventions
Doctors (and other clinicians) Should Know…

What Prescriptions Have Been Given to Their Patients By Other Practitioners

This information should be:

1. included in the patients’ electronic health care records
2. accessible through a Prescription Drug Monitoring Program (PDMP) that provides immediate information
Variation in **PDMP State Laws and Regulations** (as of February 1, 2016)

- **PDMP Authorized**
  - 49 states and DC have authorized PDMPs

- **PDMP Permitted to Share Data with other PDMPs**
  - 34 states permit sharing of PDMP data with other states’ PDMPs

- **Prescribers Required to Check PDMP**
  - 13 states require prescribers to check the PDMP
Decreasing Hydrocodone Prescriptions dispensed from US retail pharmacies after DEA Rescheduled Hydrocodone to Schedule 2

Doctors Continue to Prescribe Opioids for Ninety-one Percent of Overdose Patients

In a 2-year follow-up of 2848 commercially insured patients (from 2000 to 2012) who had a nonfatal opioid overdose during long-term opioid therapy:

- **63%** of high-dose opioid patients were still on a high dose 31-90 days after overdosing.
- **17%** of high-dose patients overdosed again within two years.
- **14%** of high-dose patients were on moderate dose.
- **13%** of high-dose patients were on low dose.
- **10%** of high-dose patients were on none.
- **33-39%** of those with active opioid prescriptions during follow-up also were prescribed benzodiazepines.

Three Pillars of CDC’s Prescription Drug Overdose Prevention Work

- **Improve data** quality and track trends
- Supply **healthcare providers** with resources to improve patient safety
- **Strengthen state efforts** by scaling up effective public health interventions

http://www.cdc.gov/washington/testimony/2015/t20150501.htm
Recent Landscape for Guidelines:
- Small Number
- Outdated
- Not Conflict Free

Solution....

**Opioid Prescribing Guidelines**

- Intended for primary care providers
- Applies to patients >18 years old in chronic pain outside of end-of-life care
- Builds on joint CDC, NIDA, ONC, SAMHSA summary on “Common Elements in Guidelines for Prescribing Opioids for Chronic Pain” and the NIH Pathways to Prevention for Opioids in Treating Chronic Pain
- PUBLISHED MARCH 15, 2016
Most States Require CME for Licensure, Fewer Require Pain/Opioid Specific Education

Direct Overdose Intervention

Naloxone Distribution for opioid overdose victims--The potential for direct intervention to save lives

- Evzio auto-injector APPROVED by FDA, April 3, 2014

Naloxone Nasal Spray Development

Needle-free, unit-dose, ready-to-use opioid overdose antidote

- NARCAN nasal spray APPROVED by FDA, November 18, 2015
Variation in **State Naloxone and Good Samaritan Laws** As of February 1, 2016

- **Prescription By Standing Order Authorized**
  - 33 states have standing orders to authorize non-medical Personnel to issue naloxone

- **Prescribers Immune from Criminal And Civil Liability**
  - 27 states protect naloxone prescribers from both criminal and civil liability

- **Good Samaritan Overdose Prevention Law**
  - 36 states offer legal protections to those who call 911 to report an overdose
Retail Pharmacy Prescriptions for Naloxone Increase Markedly

- Retail prescriptions show an increase of 1170% from the 4\textsuperscript{th} quarter of 2013 to 2\textsuperscript{nd} quarter 2015.
- Outpatient prescribing of naloxone may complement community-based distribution and first responder access.

Medical Treatment May Reduce Deaths

Additional Challenge: Lack of medication-assisted treatment capacity

Rate of Opioid Abuse/Dependence
- 3.4-6.4
- 6.5-9.2
- 9.4-10.3
- 10.8-12.9

Rate of OA-MAT Capacity
- 0.7-3.0
- 3.2-4.3
- 4.4-7.2
- 7.3-16.5

(rate per 1,000 persons aged 12 years and older)

Source: Jones CM, et al. AJPH. 2015
State Successes in *Improving Treatment Capacity*

- **Massachusetts Collaborative Care Model**
  Expanded the number of DATA-waived physicians by 375% (from 24 to 114) within 3 years

- **New Mexico Project ECHO**
  Initiation of SUD-focused clinic associated with much more rapid growth in waived physicians practicing in traditionally-underserved areas compared with the rest of the US

**State-level policy interventions track with improved outcomes**

**New York**

**2012 Action:**
New York required prescribers to check the state’s prescription drug monitoring program before prescribing painkillers.

**2013 Result:**
Saw a 75% drop in patients who were seeing multiple prescribers to obtain the same drugs, which would put them at higher risk of overdose.

**Florida**

**2010 Action:**
Florida regulated pain clinics and stopped health care providers from dispensing prescription painkillers from their offices.

**2012 Result:**
Saw more than 50% decrease in overdose deaths from oxycodone.

**Tennessee**

**2012 Action:**
Tennessee required prescribers to check the state’s prescription drug monitoring program before prescribing painkillers.

**2013 Result:**
Saw a 36% drop in patients who were seeing multiple prescribers to obtain the same drugs, which would put them at higher risk of overdose.

**Sources:**
Multi-pronged approaches can save lives: Staten Island Case Study

1. data brief
2. opioid Rx guidelines
3. PSAs
4. PDMP law
5. ED opioid Rx guidelines
6. town halls and detailing campaign to promote guidelines
7. PDMP mandated use
8. PSAs

Source: MMWR, May 15, 2015 64(18):491-494
HHS Agency Priority Goal to Reduce Opioid-Related Morbidity and Mortality

By September 30th, 2017:

- Decrease by 10% the total morphine milligram equivalents (MME) dispensed.
- Increase by 15% the number of prescriptions dispensed for naloxone.
- Increase by 10% the number of unique patients receiving prescriptions for buprenorphine and naltrexone in a retail setting.

https://www.performance.gov/node/47231?view=public#apg
The President’s Opioid Initiative
Actions across federal, state, local governments and the private sector

Improve Prescriber Training
- Train >540,000 health care providers
- Double PDMP registration
- Reach >4M providers with appropriate prescribing practices messaging

Improve Treatment Access
- Double number of buprenorphine prescribers
- Double number of naloxone providers
- Reach >4M providers with opioid abuse messaging

Multiple Partners with Commitments from:
- Over 40 provider groups, including physicians, dentists, advanced practice registered nurses, physician assistants, physical therapists and educators
- CVS Health, Rite Aid and several pharmacy and pharmacist organizations (naloxone, PDMPs)
- CBS, ABC, The New York Times, Google, the National Basketball Association, and Major League Baseball will donate media space for PSAs
Key Points:

1. Prescription opioid and heroin use and addiction are major problems in USA

2. Key approaches include:
   a) Addressing the upstream driver—high rates of prescription opioid availability
   b) Increasing access to overdose intervention
   c) Increase availability of medication assisted treatment

3. Multiple responses are being implemented at the national, state and local levels
CO*RE Executive Team

Cynthia Kear, MDiv, CHCP
Senior Vice President
California Academy of Family Physicians

Penny Mills, MBA
Executive Vice President and CEO
American Society of Addiction Medicine

Anne Norman, DNP, APRN, FNP-BC
Associate Vice President of Education
American Association of Nurse Practitioners

Catherine Underwood, MBA, CAE
CEO
American Pain Society
# Collaborative for REMS Education

## Partners
- American Pain Society (APS)
- American Academy of Hospice and Palliative Medicine (AAHPM)
- American Association of Nurse Practitioners (AANP)
- American Academy of Physician Assistants (AAPA)
- American College of Emergency Physicians
- American Osteopathic Association (AOA)
- American Society of Addiction Medicine (ASAM)
- California Academy of Family Physicians (CAFP)
- Healthcare Performance Consulting (HPC)
- Interstate Postgraduate Medical Association (IPMA)
- Nurse Practitioner Healthcare Foundation (NPHF)
- Medscape
- Physicians Institute for Excellence in Medicine which coordinates 15 state medical societies

## Strategic Partners
- Conjoint Committee on CME
- American Academy of Family Physicians

**Interdisciplinary**
**Interprofessional**
**Primary Care**
**Specialists**
**Education only**
**Founded in 2010**

**Representing 750,000+ Prescribing Clinicians**
Issues To Be Addressed by CO*RE:

• Challenges of current “opioid” environment
• Customary and usual CE/CME
• Definition of “success”
Increased Visibility on Opioids But...
Persistent Confusion

- REMS
  
  What it is?
  Even if understood, what is compelling value to “voluntary” learner
  CE/CME is a very crowded/competitive field

- Increased “visibility” of opioid epidemic
  
  - At the National Level:
    ONDCP/ HHS/National Pain Strategy/ CDC & CDC Guidelines / NIH/NIDA SAMHSA/ Surgeon General
  
  - At the State Level
    Wide range of state legislation, CE/CME requirements, PDMPs, basic awareness, knowledge and varying approaches/solutions

Result: low awareness, fragmentation, learner confusion
Accredited Education:

Why the ER/LA Opioid REMS Is Not Customary or Usual CE/CME
## Typical CE/CME and ER/LA Opioid REMS

<table>
<thead>
<tr>
<th>Element</th>
<th>Typical Live</th>
<th>Typical Online</th>
<th>ER/LA REMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration</strong></td>
<td>30 to 60 minutes</td>
<td>30 to 60 minutes</td>
<td>120 to 360 minutes+</td>
</tr>
<tr>
<td><strong>Assessment/Evaluation</strong></td>
<td>Short</td>
<td>Short</td>
<td>Long, challenging</td>
</tr>
<tr>
<td><strong>Reporting</strong></td>
<td>PARS, mid and final report</td>
<td>PARS, mid and final report</td>
<td>CO*RE Data Base, PARS, RPC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Quarterly, Various Audits &amp; Data Scrubbing</td>
</tr>
<tr>
<td><strong>Tracking</strong></td>
<td>Learner metrics &amp; demographics</td>
<td>Learner metrics &amp; demographics</td>
<td>Myriad: Different learners categories; 4 Mebiquitous definitions; RPC Unique ID #s</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Important</td>
<td>Important</td>
<td>LTE / CO*RE</td>
</tr>
</tbody>
</table>
Moore’s Levels of Outcomes

- Level 1 Participation
- Level 2 Satisfaction
- Level 3A Declarative Knowledge
- Level 3B Procedural Knowledge
- Level 4 Competence
- Level 5 Performance
- Level 6 Patient Health
- Level 7 Community Health
### REACH as of 2/28/16

<table>
<thead>
<tr>
<th></th>
<th># of Activities</th>
<th>Learners</th>
<th>Completers</th>
<th>Prescribers Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Grants</td>
<td>526</td>
<td>135,433*</td>
<td>87,402</td>
<td>28,857</td>
</tr>
</tbody>
</table>

*Additionally CO*RE has educated **34,700** nurses, pharmacists and other HCPs, bringing our total learner reach to **170,133** since our first activity in March 2013.*
Success: Level 1 Participation

170,133 LEARNERS
In 3 Years

By Comparison to Other Acknowledged Successful CE/CME Collaborations

<table>
<thead>
<tr>
<th></th>
<th>Number of Learners</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS2Day / 5 Years</td>
<td>60,000</td>
</tr>
<tr>
<td>Team A / 4 Years</td>
<td>76,200</td>
</tr>
</tbody>
</table>
"Learner Definition" Driven CE/CME...

Physician, NP and PA Learners

Learners of Entire Curriculum

Learners of Entire Curriculum Who Complete Entire Assessment Successfully

Learners of Entire Curriculum Who Complete Entire Assessment Successfully AND are Schedule II and III Prescribers

Learners of Entire Curriculum Who Complete Entire Assessment Successfully AND Have Prescribed an ER/LA Within the Past Year
Moore’s Levels of Outcomes

Level 7 Community Health
Level 6 Patient Health
Level 5 Performance
Level 4 Competence
Level 3B Procedural Knowledge
Level 3A Declarative Knowledge
Level 2 Satisfaction
Level 1 Participation

Does
Knows
How Many
Success – Level 3 Knowledge Assessment Scores

Prescriber Scores by Specialty

- **Non-pain specialist**: 80% (Live, N=9141) vs. 75% (Online, N=6463)
- **Pain Specialist**: 83% (Live, N=9141) vs. 78% (Online, N=6463)
- **Primary Care**: 79% (Live, N=9141) vs. 71% (Online, N=6463)
Success – Level 5 Performance
Implemented Changes in Practice

- No Changes [PERCENTAGE]: 8%
- Referring Pts [PERCENTAGE]
- Counseling Pts [PERCENTAGE]
- Managing Tx [PERCENTAGE]
- Initiating Tx [PERCENTAGE]
- Assessment [PERCENTAGE]
- Other [PERCENTAGE]: 4%
Additionally, We Are Reaching Learners Who Are Prescribing ER/LA AND IR/SA Opioids
From CO*RE’s Perspective

• ER/LA Opioid REMS is a **significant success** by all definitions employed by accredited providers, our industry and by standards universally used to measure learner engagement and learner change.

• The metric of 320,000 associated with the ER/LA Opioids REMS is a limiting, narrow category of prescribers that bears no correlation to measures by which CE/CME is evaluated and deemed successful.
CO*RE Recommendations:

- Continued use of accredited CE/CME
  - Well established, widely accepted uniform measures to track performance outcomes and evaluate overall success
  - Safeguards against content bias
- Inclusion of IR/SA opioids
- Inclusion of ALL appropriate health care team members
- Adult Education
  - Consider established, proven principles of adult education
  - Embed an Adult Education Professional (with CE/CME knowledge and experience) into the planning and decision making processes
- Stream line processes; don’t add to an already onerous reporting and tracking burden
- Stream line opioid efforts, especially at a national level but also in conjunction with states
  - Reduce number of free federally funded trainings on same topic
Thank you.

ckear@familydocs.org
www.core-rems.org
ER/LA Opioid REMS Education: A Clinical Perspective

Kevin Zacharoff, MD
Faculty, SUNY Stony Brook School of Medicine
Medical Director, PainEDU.org
Initial Thoughts

• 80,000 voluntarily registered users of PainEDU.org
  – Already interested in pain education
  – Established reputation and relationship

• 2,000 additional target clinicians in Montefiore/Einstein System
Preliminary Survey

• Online spot survey of 130 healthcare providers
  – 58% Physicians
  – 33% Nurse/Nurse Practitioner/Advanced Practice Nurse
  – 5% Physician Assistants

• Ascertain familiarity of REMS
• Gauge likelihood of prescribing ER/LA opioid
• Assess likelihood of educational participation
• Identify potential barriers
Familiarity with ER/LA Opioid REMS

- Somewhat Familiar: 47%
- Very Familiar: 20%
- Not at all Familiar: 26%
- Extremely Familiar: 7%
Likelihood of Prescribing ER/LA Opioids for Moderate to Severe Chronic Pain

- Extremely Likely: 31%
- Very Likely: 26%
- Somewhat Likely: 25%
- Not Likely: 9%
- Don’t Prescribe: 9%
Likelihood of Participating in a Voluntary ER/LA Opioid REMS Course

- Definitely Would: 57%
- Probably Would: 35%
- Probably Would Not: 6%
- Definitely Would Not: 2%
Potential Barriers

- The two most common barriers identified by participants that would likely hinder participation in an ER/LA opioid REMS education course:
  - The belief that the time commitment would be too burdensome (50%)
  - Lack of understanding of what the education course would cover (23%)

- A web-based course was the most commonly preferred method of delivery for the majority of survey participants (88%)

- A print-based course being second most preferred (39%)
Learner Variation

• Differing educational needs among prescribers
  – Expert
  – Non-expert

• Many good candidates for education beyond prescribers
  – Nurses
  – Pharmacists
  – Clinicians in training
  – Prescribers of IR/SA opioid analgesics

Challenges

• Mode of delivery
  – Live presentation
    • Captive audience
    • Not as efficient as online program
  – Online program
    • Reasonably good registration and initiation
    • Decreased rate of completion
Evaluation of Educational Needs

• Evaluation integrated into the REMS program modules
• Analysis of 955 participants
  – 67% Physicians
  – 26% Nurse Practitioners
  – 5% Physician Assistants
  – 2% Other
• 39% self-identified as pain specialists
• 28% self-identified as primary care
## Evaluation Results

<table>
<thead>
<tr>
<th>EVALUATION</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Common Challenges with Chronic Pain</strong></td>
<td></td>
</tr>
<tr>
<td>Psychological complexity of patients</td>
<td>68%</td>
</tr>
<tr>
<td>Poor patient adherence/satisfaction</td>
<td>50%</td>
</tr>
<tr>
<td>Time constraints</td>
<td>42%</td>
</tr>
<tr>
<td><strong>Common Challenges with Opioid Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>Subjectivity of pain/severity</td>
<td>45%</td>
</tr>
<tr>
<td>Pressure from patients for opioids</td>
<td>39%</td>
</tr>
<tr>
<td>Difficulty predicting risk of ADRBs</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Most Common Influencers of Prescribing</strong></td>
<td></td>
</tr>
<tr>
<td>Clinical practice guidelines</td>
<td>60%</td>
</tr>
<tr>
<td>Patient factors (pain type, attitude)</td>
<td>51%</td>
</tr>
<tr>
<td>State guidelines and regulations</td>
<td><strong>44%</strong></td>
</tr>
</tbody>
</table>
Clinical Perspectives

• Consider additional learner groups
  — Non-prescribers play a critical role on the health care team in the initiation, management, and monitoring of opioids with patients
  — Pharmacists likely have larger role to play
  — Clinicians in training
    • Seat-belt approach

• Explore additional methods of delivery
  — e.g., Inservice education

• Clinical relevance is key
  — May be defined by clinical expertise

Clinical Perspectives

- Non-prescribers often play a critical role on the health care team in the initiation, management and monitoring of opioids with patients
- Take the lead in counseling, discussing and consulting about these medications with patients
- 24% of these non-prescribers actually recommend whether or not opioids should be initiated
Clinical Perspectives

• Learners identified IR/SAs often as much of a challenge as ER/LAs
  – Value of educating clinicians who are actively prescribing IR/SA opioids is likely high
  – While this metric might not align with prior FDA-defined intent, all stakeholders could likely recognize patient-transferable benefits from this education
Summary

• Merge real-world challenges/barriers with educational content
  – Tailoring based on expertise?

• Alignment with/facilitated dissemination of guidelines and recommendations

• Targeting multiple disciplines

• Utilize existing educational forums

• ER/LA vs. IR/SA opioid analgesics
Educating Clinicians in ER/LA Opioid REMS:
Experiences of the Conjoint Committee on Continuing Education

Norman Kahn, MD
Executive Vice President and CEO
Council of Medical Specialty Societies (CMSS)
Convener, Conjoint Committee for Continuing Education
Disclosure of Relationships

• EVP/CEO, Council of Medical Specialty Societies
• Member, Board of Directors, Friends of the National Library of Medicine
CCCE Member Organizations

Accreditation Council for Continuing Medical Education
Accreditation Council for Graduate Medical Education
Accreditation Council for Pharmacy Education
Alliance for Continuing Education in the Health Professions
Alliance of Independent Academic Medical Centers
American Academy of Family Physicians
American Association of Colleges of Nursing
American Association of Nurse Practitioners
American Association of Colleges of Osteopathic Medicine
American Academy of Physician Assistants
American Board of Medical Specialties
American College of Physicians
American Dental Education Association
American Hospital Association
American Medical Association
American Nurses Credentialing Center
American Osteopathic Association
Association for Hospital Medical Education
Association of American Medical Colleges
Council of Medical Specialty Societies
Federation of State Medical Boards
Joint Commission
Journal of Continuing Education in the Health Professions
Medbiquitous
National Board of Medical Examiners
Society for Academic Continuing Medical Education
Conjoint Committee on Continuing Education: Objectives

• To use the continuing education of health professionals to improve the performance of the U.S. health care system

• The CCCE’s strategic focus is to voluntarily educate prescribers of long-acting opioid analgesics, and their practice teams, in Risk Evaluation and Management Strategies (REMS). It is the hope of the various health professions that we can use our educational tools to help stem this public health crisis.
CCCE, FDA and RPC

• Collaboration to address ER/LA Opioid REMS

• Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics
Successful Strategies

• Quality educational activities
  • On-line (more participants)
  • Live (more completers)
  • Incorporate the Blueprint
  • Tailored to need

• Quantity educated
  • >647 activities
  • >200,000 educated
  • >167,947 completed education (ACCME PARS)
  • Prescribers and practice team members
  • Tailored to audience (rural NP vs oncologist vs dentist)
Healthcare is delivered in teams.
Practice Characteristics

2,000 patients in panel
Challenges

• Rarely prescribing - therefore not recognizing such education as a priority
• The prescriber is the expert - therefore not sensing a need to take advantage of the education
• Lack of awareness
• Trusting enforcement to manage the problem
• Requiring 2-3 hours of education discourages some from participating
• Mandated state CE other than pain management or opioid prescribing - results in clinicians forgoing opioid education to fulfill other requirements
• Overwhelmed by the many demands on practice
Practice Burdens

- Electronic Health Records – add time and make workflow complex
- Performance Measurement – multiple measures for multiple payers
- Maintenance of Certification – perceptions of relevance
- Payment Reform – preparing for moving from PQRS and MU to APMs and MIPS
Typical Responses

• “I see the need to improve my practice in this challenging area” (>200,000)
  or...
• “I don’t prescribe very often, I’m not part of the problem, I don’t have time (or energy) for one more thing ... so I’ll pass”
Mandatory vs Voluntary Education

• Nineteen states mandate CE
  • End of life care
  • Domestic violence
  • Infection control
  • HIV/AIDS
  • Bioterrorism
  • Pain management (13 states)

• Mandatory CE is perceived as burden and results in “box-checking” behavior – seeking credit, not learning or practice change
  • “Let’s get it over with and go back to practice as usual”

• Voluntary CE is self-assessment of need – seeking learning and practice change more than credit
Alignment of Federal Agencies

• FDA
• DEA
• ONDCP
• HHS
• CDC
• Surgeon General
• SAMHSA
• NIDA
• HRSA
National Overdose Deaths
Number of Deaths from Prescription Opioid Pain Relievers

Source: National Center for Health Statistics, CDC Wonder
National Overdose Deaths
Number of Deaths from Heroin

Source: National Center for Health Statistics, CDC Wonder
Future Considerations

• Didactic/interactive CE
  • Learning
  • Intention to change

• Performance Improvement CE
  • Develop performance measures, measure, educate, re-measure after time

• Clinical Data Registry
  • Develop performance measures, measure, provide feedback = gap analysis, educate, implement change, re-measure, demonstrate improvement continually over time
A COORDINATED REGULATORY AND EDUCATIONAL APPROACH TO THE PUBLIC HEALTH CRISSES OF CHRONIC PAIN AND ADDICTION

Joanna G. Katzman, MD, MSPH
Associate Professor
University of New Mexico
Director, UNM Pain Center & ECHO Pain
GOAL

- Mandated Continuing Education specific to Pain and Opioid Substance Disorder for *all clinicians with prescriptive authority*

- Positive effects on dispensing of high dose opioids, benzodiazepines, and overdose deaths

- Combined with robust Prescription Drug Monitoring Program use
DRUG POISONING DEATH RATES* BY STATE: UNITED STATES, 2013

* NOTE: Drug poisoning death rates are age-adjusted deaths per 100,000 standard population.

NEW MEXICO- PRESCRIPTION DRUG AND HEROIN OVERDOSE

- 2016- # 2 for opioid-related overdose deaths
- Fifth largest state with 2 Million
- Diversity includes: Hispanics and American Indians-with 29 pueblos and much of the Navajo Nation
- Top 5 most impoverished states per capita
- Heroin epidemic throughout decades in New Mexico
- Increasing heroin deaths throughout the state now due to black tar heroin
Drug Overdose Death Rates in New Mexico

2012-2014

Below US Average
1.5x Above US Average
2x Above US Average
>4x Above US Average
>6x Above US Average
2012- NEW MEXICO SENATE BILL 215
REVISED PAIN RELIEF ACT

- Passed 68-0 in House, 31-8 in Senate
- Requiring all healthcare licensing boards to mandate continuing medical education (CME) related to Chronic Non Cancer pain for all clinicians with prescriptive authority
- The Bill also mandated the formation of a “Governor’s Advisory Council” composed of key stakeholders to review prescription drug misuse, overdose prevention and pain management
Requirements (for MD/PA):

1. **Immediate 5 hours** of CME in pain/addiction between Nov 1, 2012 and June 30, 2014.

2. *and* at every renewal cycle

3. Every New Mexico healthcare licensing board followed the immediate one-time 5 hour training and also created very similar rules regarding CME.
COURSES (16.10.14) MUST INCLUDE:

- 1-understanding of pharmacology and risk of controlled substances,
- 2-a basic awareness of addiction
- 3-abuse and diversion
- 4-state and federal requirements for controlled substance prescribing
- 5-management of pain
Prescription Drug Monitoring Program (PDMP) requirements

1. PDMP registration
2. Checking PDMP upon initial prescription (if more than 10 days)
3. And every 6 months thereafter

March 2016-

New Mexico passed legislation to mandate PDMP usage upon initial prescription (if more than 4 days) and every 3 months and
Treating Chronic Pain and Addiction in the Southwest: Addressing Best Practices and Current Regulations

These courses are approved by all New Mexico licensing boards to fulfill the requirements specific to pain and addiction. Clinicians in neighboring states of AZ, CO, TX and UT are welcome to attend.

This course will provide a separate dentistry specific plenary track.

Presented by:

UNM School of Medicine
UNM Pain Consultation & Treatment Center
Department of Neurosurgery
Topics included:

1. Overview of opioid overdose crisis nationally and statewide
2. Use of Non-Opioid Medications (and other non-pharmacological treatments) for pain management
3. Identification of Patients at risk for opioid substance use disorder, misuse, diversion
4. Pediatric/Adolescent Pain Management
5. Federal and State Laws pertaining to controlled substances and PDMP
CLINICIANS PARTICIPATED IN 2 OF THE FOLLOWING 5 BREAKOUT SESSIONS:

1. Safe(r) Opioid prescribing
2. Management of the patient who is misusing opioids
3. Pediatric/Adolescent Pain
4. Pain and Psychiatric co-morbidities

*Dental Pain (began in 2013 courses)*
STUDY METHODS:

- IRB approval
- Pre-post course surveys in:
  - Knowledge (10 item validated tool)
  - Self efficacy survey (7 item validated tool)
  - Attitudes regarding patients suffering with pain (Know Pain-12)

- Study participation voluntary and had no bearing on receiving the 5 hours of CME
The Public Health Crises of Chronic Pain and Addiction

Rules and Values: A Coordinated Regulatory and Educational Approach to the Public Health Crises of Chronic Pain and Addiction

Joanna G. Katzman, MD, MSPH, George D. Comerci, MD, Michael Landen, MD, MPH, Larry Loring, RPh, Steven M. Jenkusky, MD, MA, Sanjeev Arora, MD, Summers Kalishman, PhD, Lisa Marr, MD, Chris Camarata, MD, Daniel Duhigg, DO, MBA, Jennifer Dillow, MD, Eugene Koshkin, MD,
RESULTS:

- 6 courses studied between Nov 3, 2012- May 18, 2013:
  - 4 courses – Albuquerque, New Mexico (at 2 different locations)
  - 1 course- Santa Fe, New Mexico
  - 1 course- Las Cruces, New Mexico

- 1090 clinicians attended the course; 99% participation rate
  - 67% MD/DO
  - 30% PA/NP
  - 3% DDS, CNM, Pharm D, Psychologists
### Table 2: Chronic Pain One Day Survey Summary

#### Chronic Pain Knowledge Survey

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre Mean</th>
<th>Post Mean</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>Student’s t</th>
<th>P-value</th>
<th>Effect Size(d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test Score (10 Possible)</td>
<td>7.04</td>
<td>8.78</td>
<td>1075</td>
<td>1.74</td>
<td>1.68</td>
<td>34.01</td>
<td>&lt;0.0001</td>
<td>1.04</td>
</tr>
<tr>
<td>Percent Score (100% possible)</td>
<td>70.4%</td>
<td>87.8%</td>
<td>1075</td>
<td>17.4%</td>
<td>16.8%</td>
<td>34.01</td>
<td>&lt;0.0001</td>
<td>1.04</td>
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</tbody>
</table>

#### Chronic Pain Self-Efficacy

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre Mean</th>
<th>Post Mean</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>Student’s t</th>
<th>P-value</th>
<th>Effect Size(d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Rating (7 Possible)</td>
<td>4.56</td>
<td>5.47</td>
<td>1073</td>
<td>0.91</td>
<td>0.85</td>
<td>34.80</td>
<td>&lt;0.0001</td>
<td>1.06</td>
</tr>
<tr>
<td>Percent Rating (100% possible)</td>
<td>65.2%</td>
<td>78.1%</td>
<td>1073</td>
<td>12.9%</td>
<td>12.2%</td>
<td>34.80</td>
<td>&lt;0.0001</td>
<td>1.06</td>
</tr>
</tbody>
</table>

#### Know-Pain 12 Survey

##### Overall Rating: Tests for Significance

*Note: Scores were adjusted to be unidirectional for the overall analysis, with the higher number being the ideal direction of improvement.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre Mean</th>
<th>Post Mean</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>Student’s t</th>
<th>P-value</th>
<th>Effect Size(d)</th>
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<tbody>
<tr>
<td>Overall Rating (6 Possible)</td>
<td>4.23</td>
<td>4.66</td>
<td>1052</td>
<td>0.44</td>
<td>0.39</td>
<td>35.63</td>
<td>&lt;0.0001</td>
<td>1.10</td>
</tr>
<tr>
<td>Percent Rating (100% possible)</td>
<td>70.5%</td>
<td>77.8%</td>
<td>1052</td>
<td>7.3%</td>
<td>6.6%</td>
<td>35.63</td>
<td>&lt;0.0001</td>
<td>1.10</td>
</tr>
<tr>
<td>Time Period</td>
<td>Opioid Prescriptions Filled</td>
<td>Total MME of Opioids Dispensed</td>
<td>Opioid MME per prescription</td>
<td>Benzodiazepine Prescriptions Filled</td>
<td>Total VME of Benzodiazepines Dispensed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------</td>
<td>--------------------------------</td>
<td>-----------------------------</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>2008 Jan-Jun</td>
<td>748,518</td>
<td>835,798,584</td>
<td>1,117</td>
<td>330,192</td>
<td>208,790,533</td>
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<tr>
<td>2008 Jul-Dec</td>
<td>748,716</td>
<td>838,432,412</td>
<td>1,120</td>
<td>334,092</td>
<td>215,025,059</td>
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<tr>
<td>2009 Jan-Jun</td>
<td>782,970</td>
<td>872,458,043</td>
<td>1,114</td>
<td>352,051</td>
<td>230,144,820</td>
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<tr>
<td>2009 Jul-Dec</td>
<td>783,379</td>
<td>920,667,804</td>
<td>1,175</td>
<td>355,856</td>
<td>234,702,614</td>
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<tr>
<td>2010 Jan-Jun</td>
<td>803,663</td>
<td>980,218,843</td>
<td>1,220</td>
<td>366,773</td>
<td>247,186,367</td>
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<tr>
<td>2010 Jul-Dec</td>
<td>778,050</td>
<td>985,578,313</td>
<td>1,267</td>
<td>351,687</td>
<td>243,520,952</td>
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<tr>
<td>2011 Jan-Jun</td>
<td>809,523</td>
<td>972,977,485</td>
<td>1,202</td>
<td>355,233</td>
<td>247,584,917</td>
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<tr>
<td>2011 Jul-Dec</td>
<td>880,838</td>
<td>1,039,292,508</td>
<td>1,180</td>
<td>380,106</td>
<td>263,125,880</td>
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</tr>
<tr>
<td>2012 Jan-Jun</td>
<td>863,768</td>
<td>998,153,444</td>
<td>1,156</td>
<td>365,219</td>
<td>252,794,005</td>
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<tr>
<td>2012 Jul-Dec</td>
<td>886,416</td>
<td>969,522,667</td>
<td>1,094</td>
<td>362,415</td>
<td>250,480,873</td>
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</tr>
<tr>
<td>2013 Jan-Jun</td>
<td>896,925</td>
<td>926,180,808</td>
<td>1,033</td>
<td>358,570</td>
<td>229,931,101</td>
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</tr>
</tbody>
</table>
OPIOID PRESCRIPTIONS 2008-2015

Opioid Prescriptions by Dosage Level

% of all opioid prescriptions

% <=40 MME/day
% >40-100 MME/day
% >100 MME/day

2008 Jan-Jun
2009 Jan-Jun
2010 Jan-Jun
2011 Jan-Jun
2012 Jan-Jun
2013 Jan-Jun
2014 Jan-Jun
2015 Jan-Jun

UNM HEALTH SCIENCES CENTER
TOTAL DAYS SUPPLY AND QUANTITY (MME) OF OPIOIDS

Total Days Supply and Quantity (MME) of Opioids

Morphine Milligrams Equivalent


Total Days Supply

0 2,000,000 4,000,000 6,000,000 8,000,000 10,000,000 12,000,000 14,000,000 16,000,000 18,000,000

Total Opioid MME Days Supply of Opioids
Percent of Clinicians Providing Opioid Prescriptions over 100 MME/day

Percent of Practitioners providing Opioid prescriptions over 100 MME/day

0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0% 70.0% 80.0% 90.0%

## NEW MEXICO
### DRUG OVERDOSE DEATHS

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>513</td>
</tr>
<tr>
<td>2009</td>
<td>428</td>
</tr>
<tr>
<td>2010</td>
<td>468</td>
</tr>
<tr>
<td>2011</td>
<td>521</td>
</tr>
<tr>
<td>2012</td>
<td>486</td>
</tr>
<tr>
<td>2013</td>
<td>449</td>
</tr>
<tr>
<td>2014</td>
<td>*540</td>
</tr>
</tbody>
</table>
EVALUATION OF AMERICAN INDIAN HEALTH SERVICE TRAINING IN PAIN MANAGEMENT AND OPIOID SUBSTANCE USE DISORDER

- Indian Health Service - effective January 2015, mandating CME in pain and addiction to all clinicians with prescriptive authority-

- Using telementoring, over 1,700 clinicians now trained in pain management, and opioid substance use disorder, based on the New Mexico courses

- Mixed quantitative and qualitative results available mid-May (accepted 3/13/16 Am J Pub Health- Katzman, Fore, et al.)
REFERENCES


- New Mexico Department of Health, Division of Epidemiology (James Davis, PhD, Michael Landen, MD)


Promoting Best Practices and the Public Health with Accredited CE

May 3-4, 2016

Graham McMahon, MD, MMSc
President & CEO
ACCME
Value of Accredited CE

ACCME

• sets the standards
• performs audits and surveys
• provides clinicians the reassurance that the education they’re participating in is:
  – Balanced and evidence-based
  – Designed for relevance: real needs and gaps
  – Evaluated to guide safe, effective care
  – Free of commercial influence
Challenging Assumptions

Ballistic Trajectory

Klass D Academic Medicine 2007; 82 (6)
## Scope of the Enterprise

### 2014 Reporting Year

<table>
<thead>
<tr>
<th>Physician Interactions</th>
<th>Other Learner Interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>13,599,687</td>
<td>11,587,518</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activities</th>
<th>Hours of Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>147,024</td>
<td>1,033,615</td>
</tr>
</tbody>
</table>

1,908 Accredited Providers
As of April 2016 in ACCME's PARS database, there were 96 providers reporting 647 REMS-compliant ACCME accredited CME activities - reaching ~168,000 learners.

Opioid REMS CME Activities

**Figure 2:** FDA-defined prescribers who have successfully completed ER/LA Opioid REMS-Compliant CE activities, by profession, n=41,608.
Opioid REMS CME Activities

Activities:
- Internet Activity Enduring Material, 74
- Other, 53
- Course, 485

Participants:
- Internet Activity Enduring Material, 110,172
- Other, 25,515
- Course, 32,260
Lessons Learned & Recommendations

Lessons
• CE providers
  • Know their audiences the best
  • Are educational specialists
  • Need flexibility to meet their learners’ needs
  • Should be allowed and encouraged to innovate
• Current blueprint should be revised to focus on the principles rather than content

Recommendations
• Recognize all prescribers and teams in data
• Leverage the extensive and robust CE community as the delivery mechanism for prescriber training
Accredited CME in Support of Other REMS

- Patient Safety issues
- CE as a delivery mechanism

Accredited CME Responsiveness to Changing Healthcare Environment

- New accreditation standards in 2016
- Accredited CME system committed to continuing to improve health of the nation
- Accredited CME system committed to supporting FDA efforts to reduce risk and promote drug safety