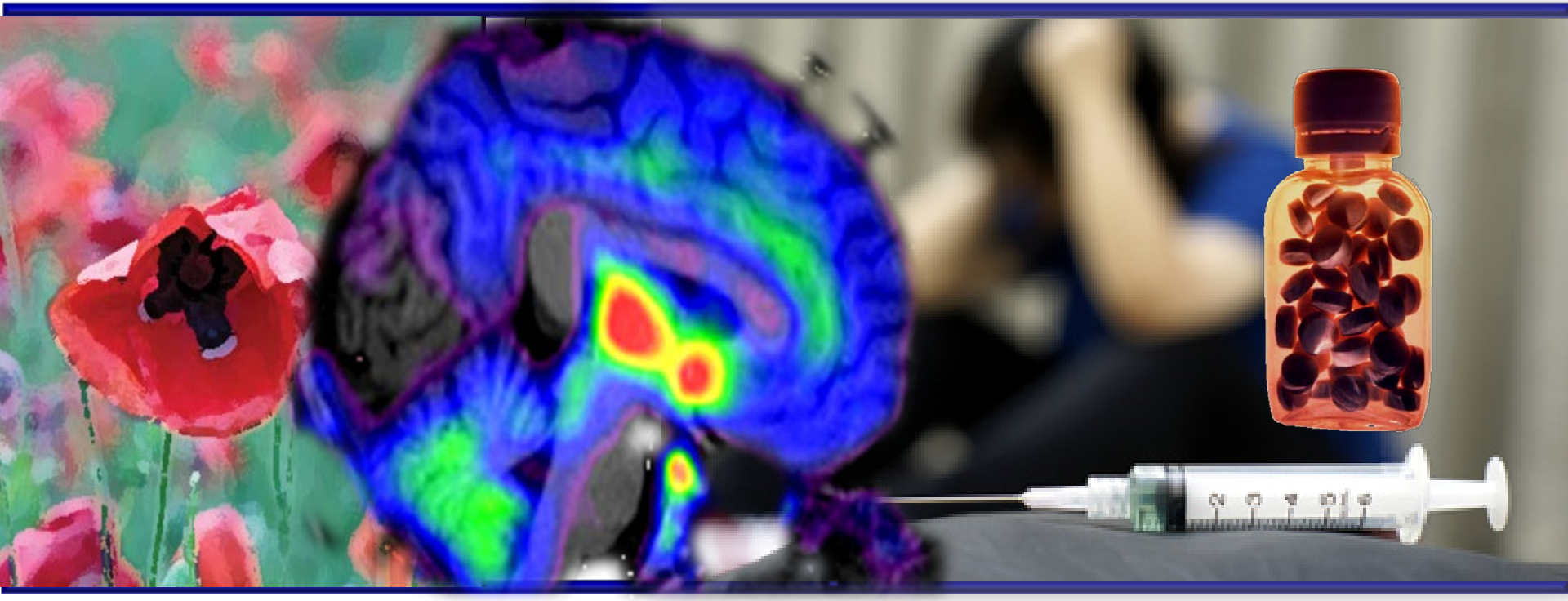
Responding to the *Opioid Morbidity and Mortality*

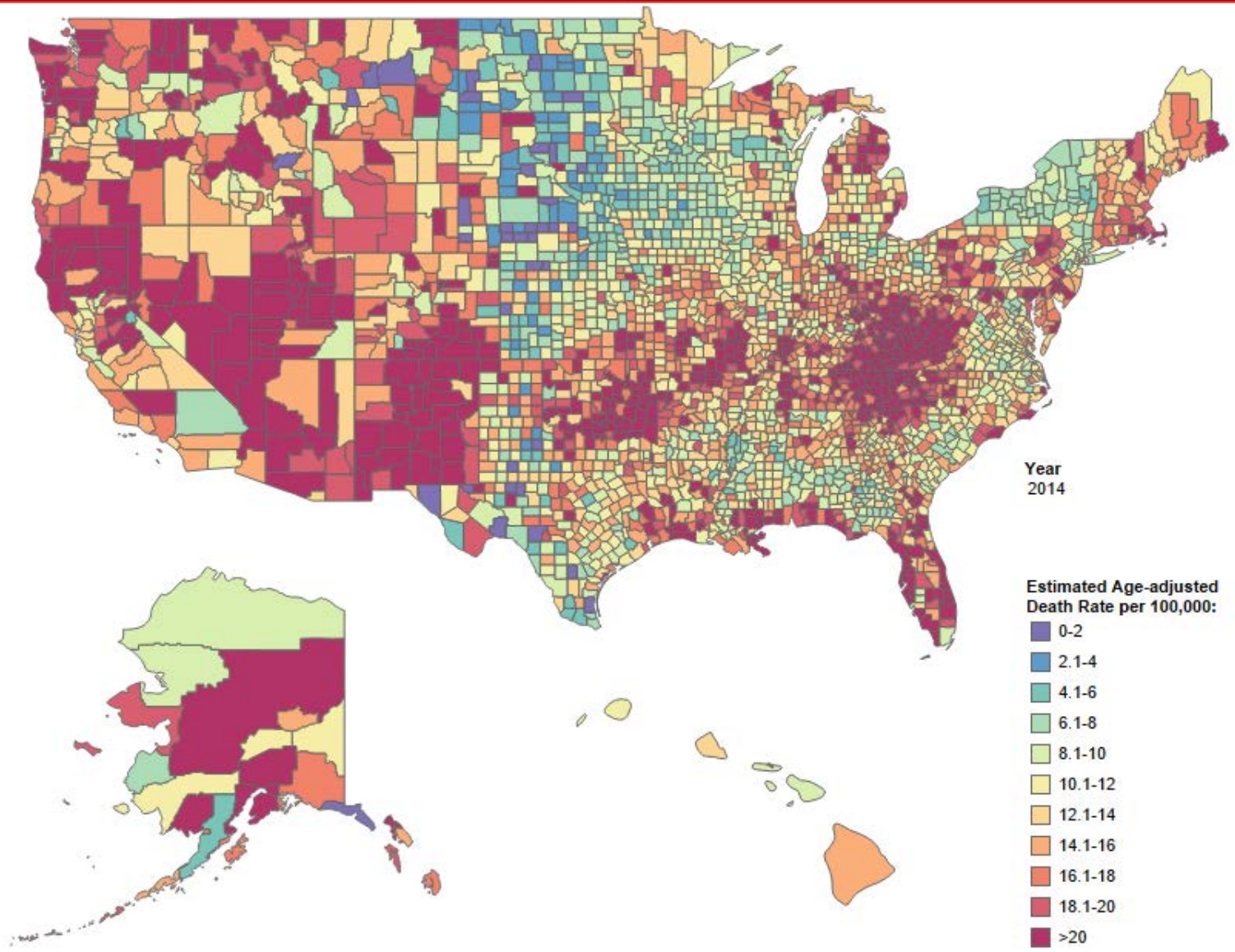


Wilson M. Compton, M.D., M.P.E.
Deputy Director
National Institute on Drug Abuse

NIH National Institute on Drug Abuse
Science = Solutions

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

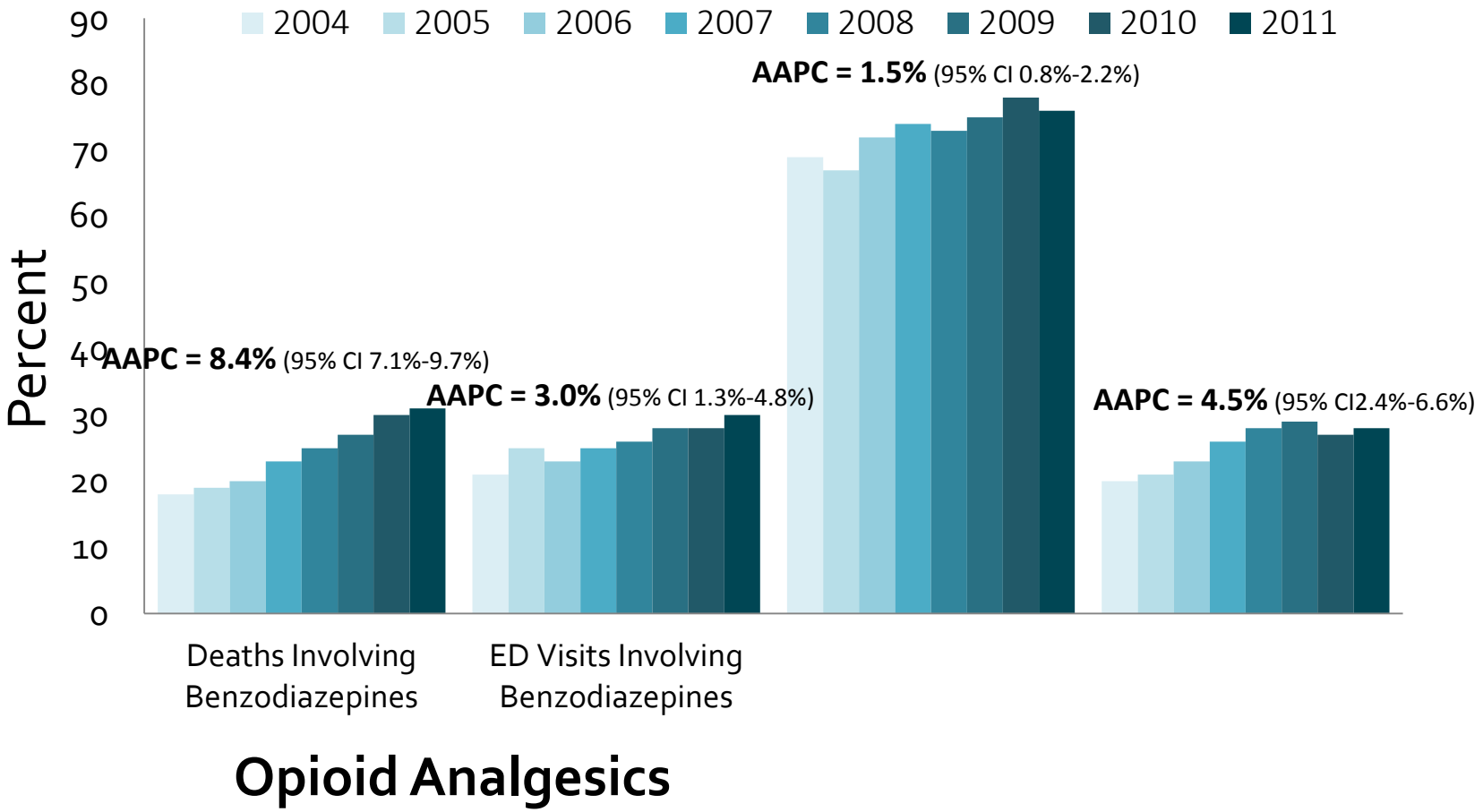
Marked *Geographic Variation in Mortality*:
Estimated Age-adjusted OD Death Rates, by County, 2014



Source: http://blogs.cdc.gov/nchs-data-visualization/drug-poisoning-mortality/

Overlap of *Benzodiazepines and Opioids*

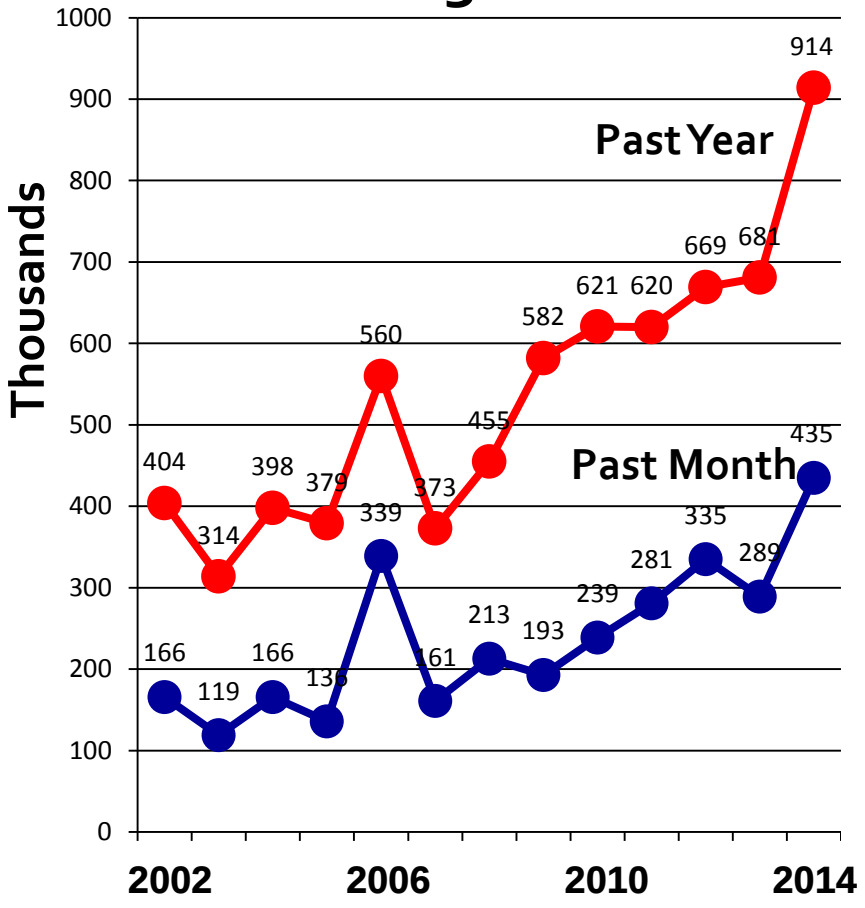
Opioid Analgesic ED Visits and OD Deaths Involving Benzodiazepines & Benzodiazepine ED Visits and OD Deaths Involving Opioids



Source: CM Jones, JK McAninch. *American Journal of Preventive Medicine* 2015;49:493-501.

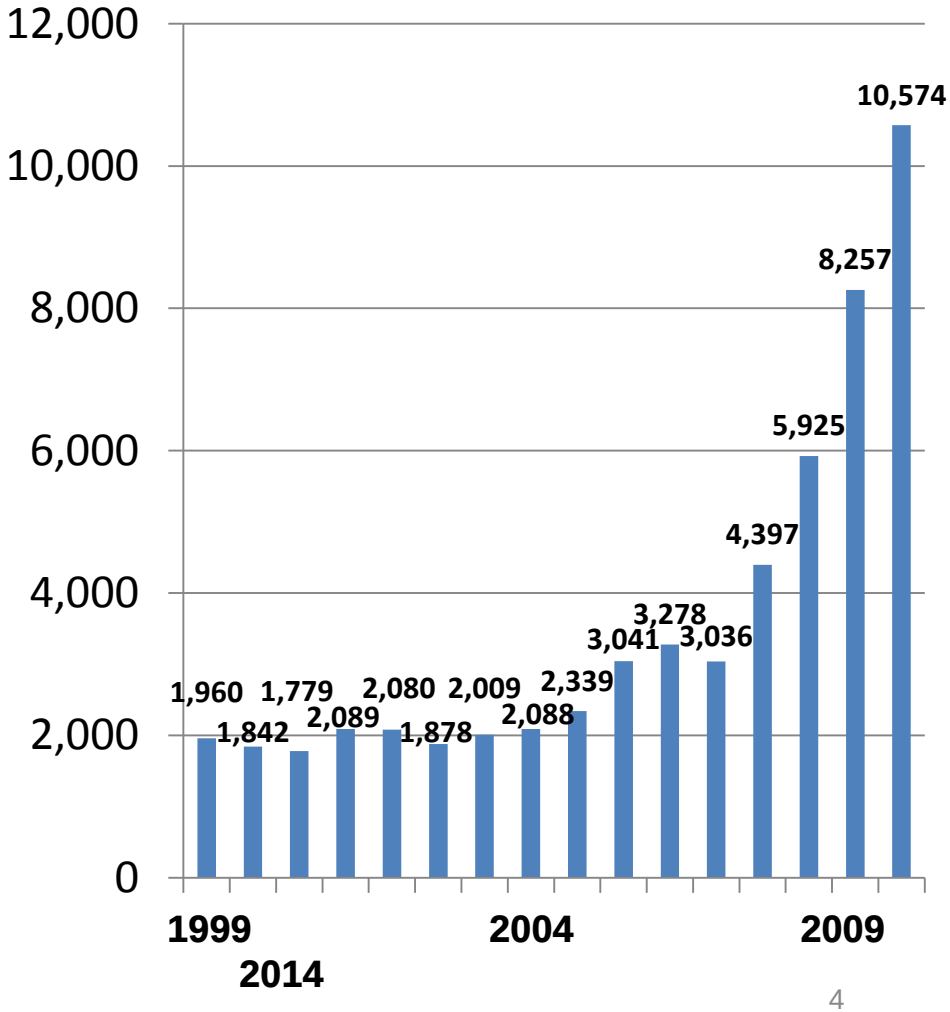
Abuse of Rx Opioids has led to a Rise in *Heroin Abuse and Associated Deaths* from Overdoses

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



SAMHSA, National Survey on Drug Use and Health.

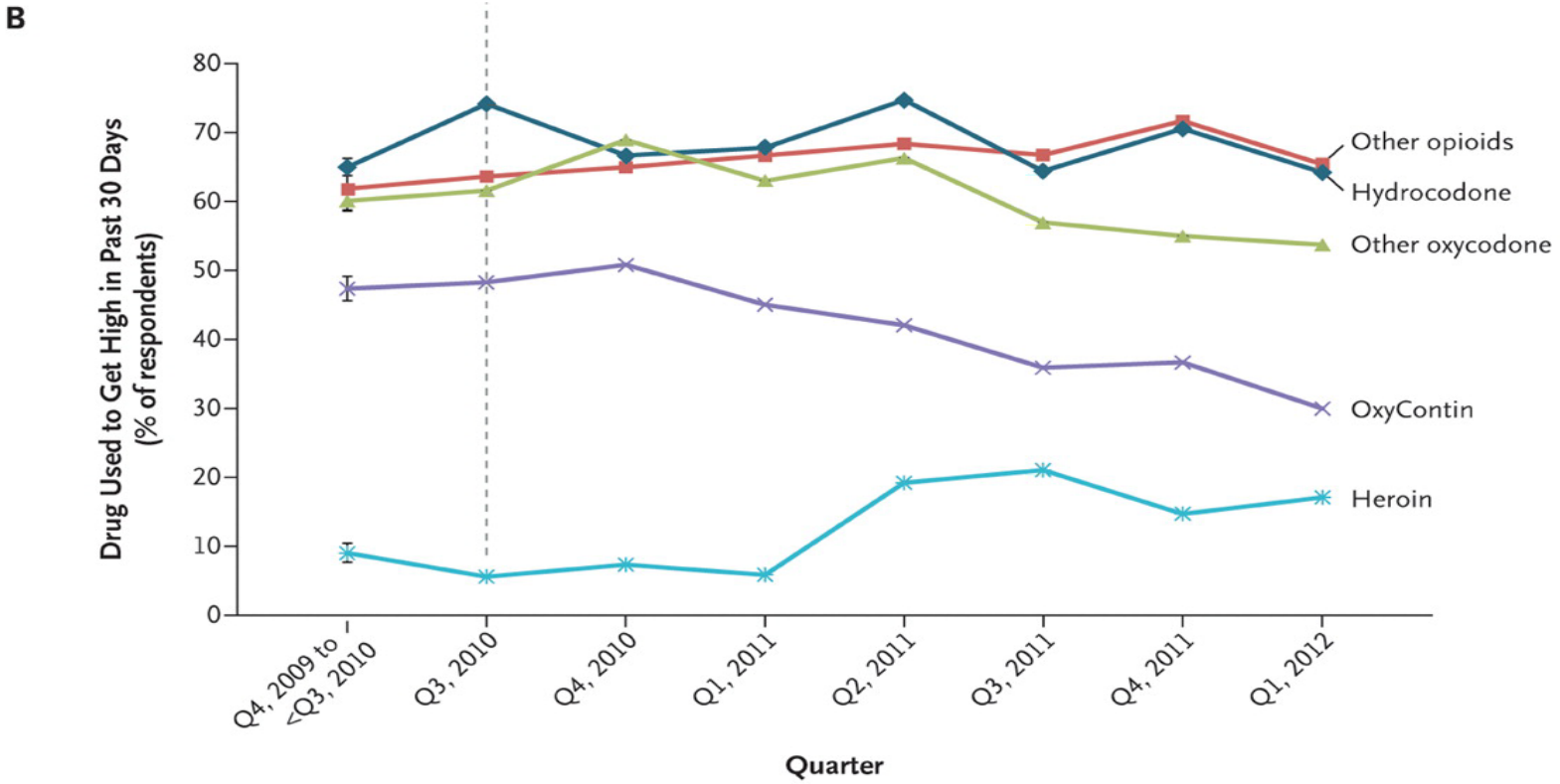
Heroin Overdose Deaths



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.*



Cicero TJ et al. *N Engl J Med* 2012;367:187-189.

Most Heroin Users Report *Previous Non-Medical Use* of Prescription Opioids,

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

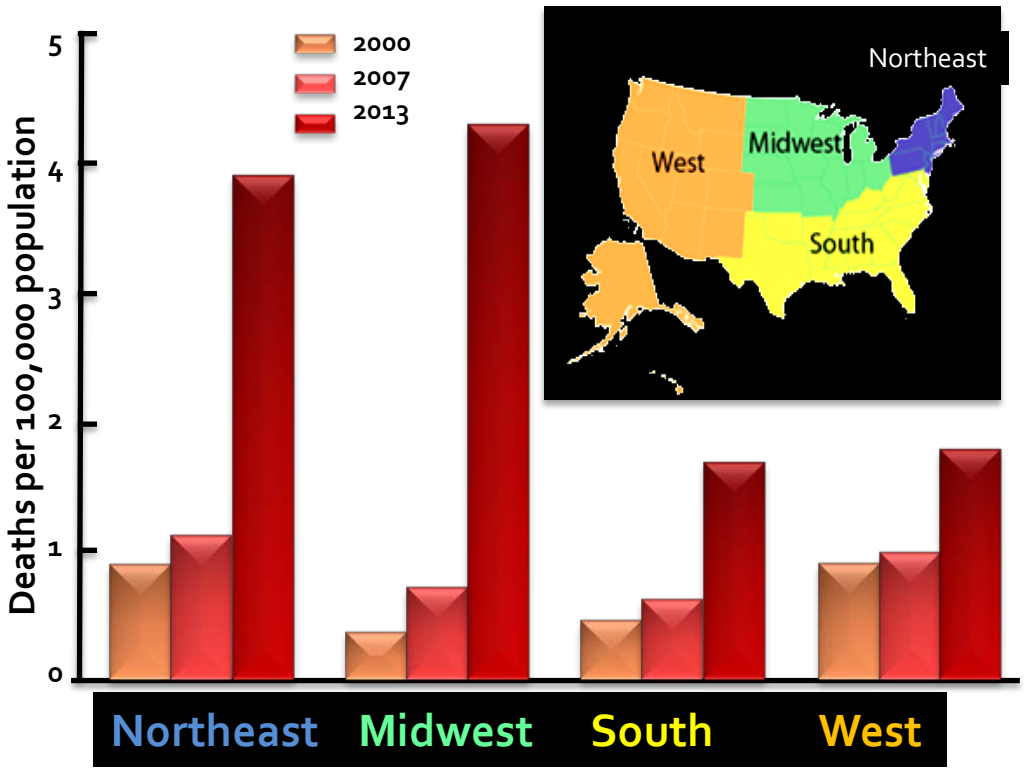
National General Population:

- **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:

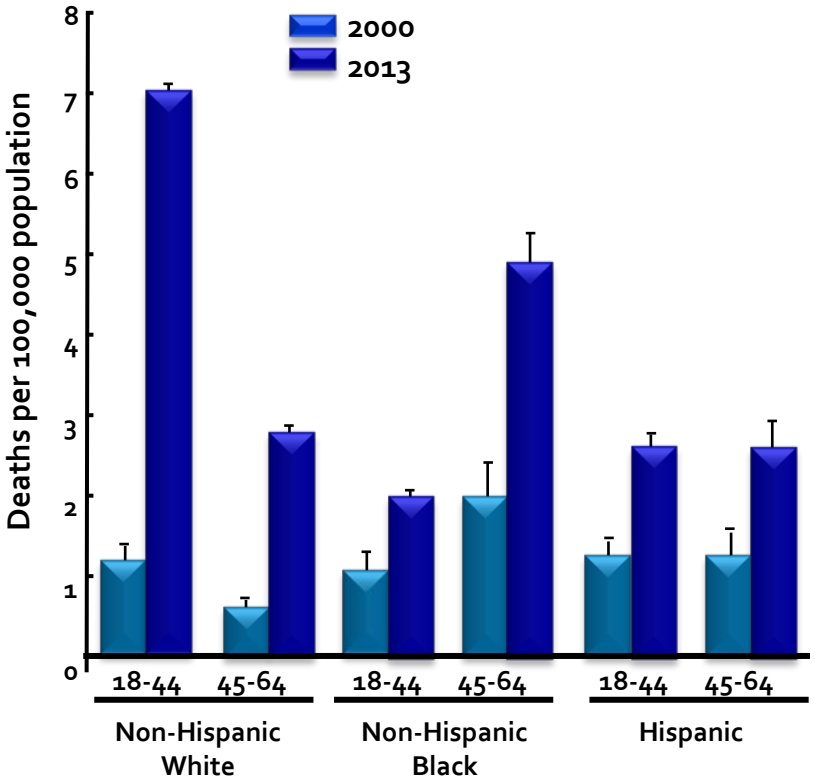
- **Within 3 years, 7.5% progressed to heroin (i.e. 2.8% per year)**
  (Carlson, Nahhas, martins, Daniulaityte. 2015)

Increases in All Regions, Especially Northeast and Midwest: *Age-Adjusted Rates for Heroin Drug-Poisoning Deaths*



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

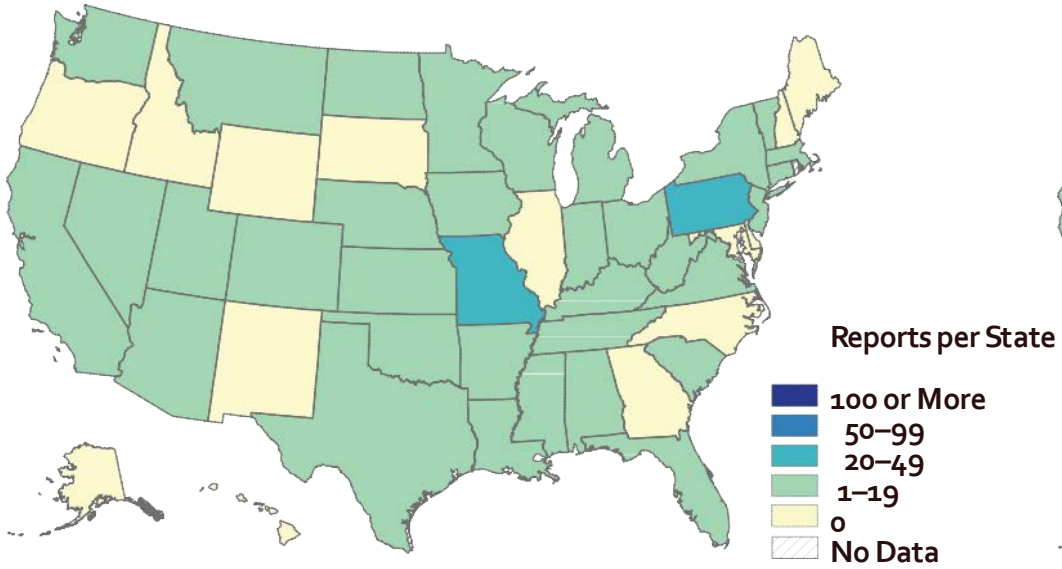
Increases for All, Especially Non-Hispanic Whites: *Heroin Drug-Poisoning Deaths by Subgroups*



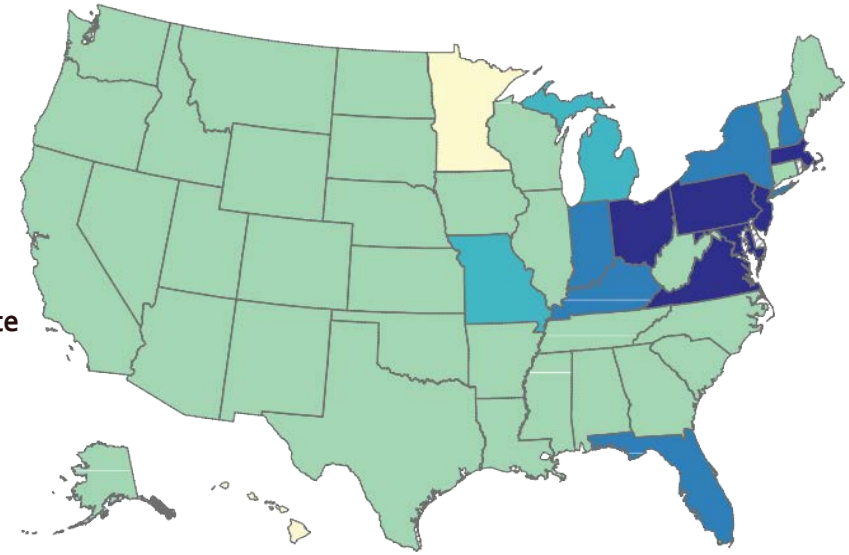
CDC, NCHS Data Brief, No 190, March 2015.

Increases in Fentanyl Reports in Northeast, Midwest and South

Jan.– June 2009



Jan.– June 2014



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

http://aspe.hhs.gov/sp/reports/2015/OpioidInitiative/es_OpioidInitiative.pdf

ADVANCING POLICY AND PRACTICE: A *50 STATE WORKING MEETING* TO PREVENT OPIOID-RELATED OVERDOSE AND ADDICTION, SEPT 17 – 18, 2015

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

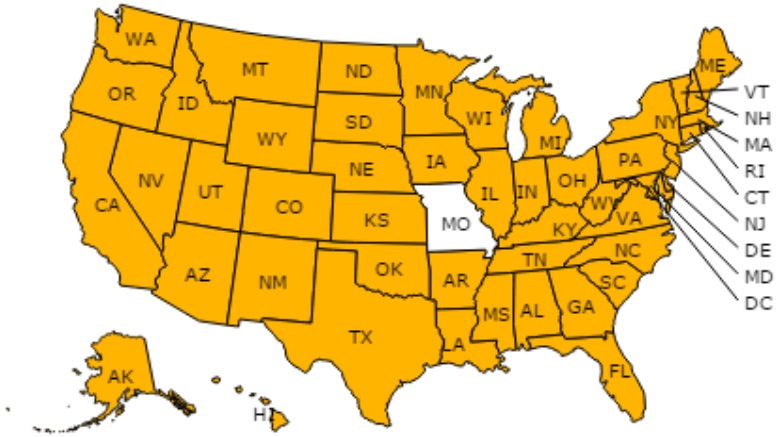
Doctors (and other clinicians) Should Know…

What Prescriptions Have Been Given to Their Patients By Other Practitioners

This information should be:

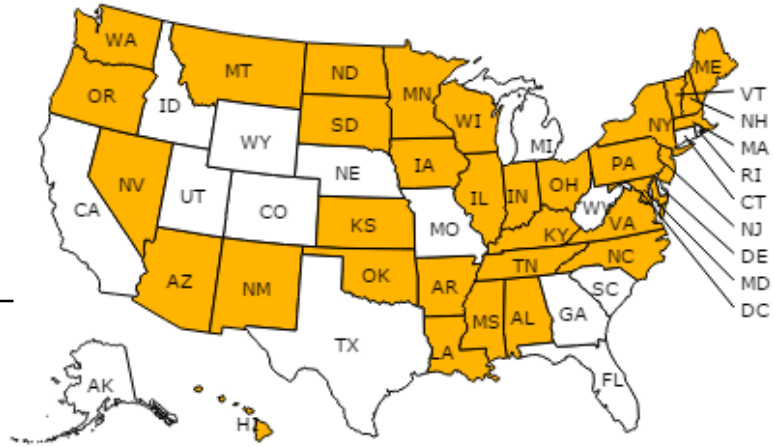
1. included in the patients' *electronic health care records*
2. accessible through a *Prescription Drug Monitoring Program (PDMP)* that provides immediate information

Variation in *PDMP State Laws and Regulations* (as of February 1,2016)



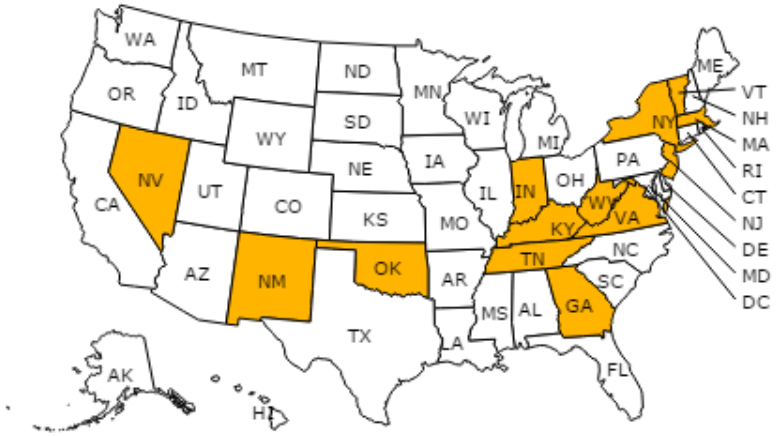
PDMP Authorized

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

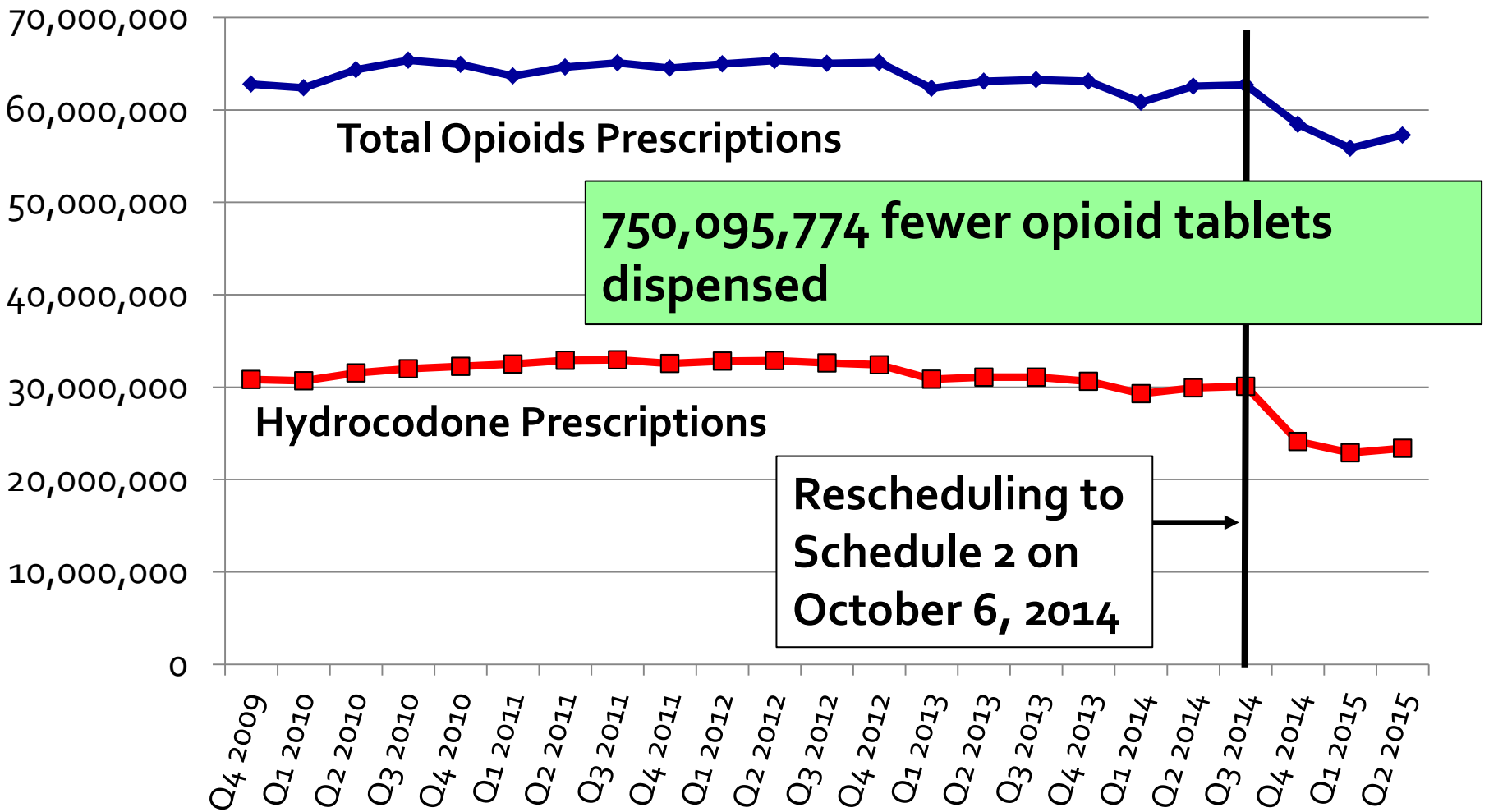


Prescribers Required to Check PDMP

13 states require prescribers to check the PDMP

PDAPS Prescription Drug Abuse Policy System

Decreasing Hydrocodone Prescriptions dispensed from US retail pharmacies after DEA Rescheduled Hydrocodone to Schedule 2

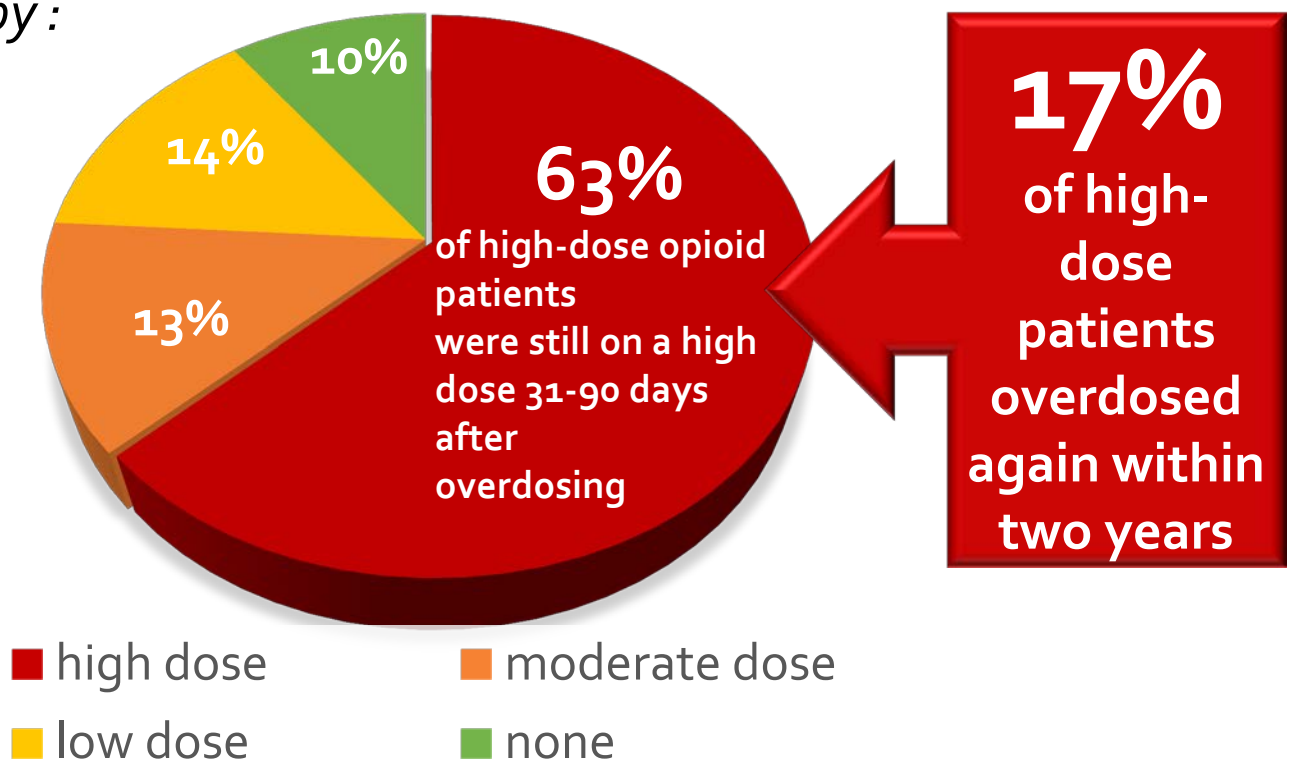


Source: CM Jones, PG Lurie, DC Throckmorton. *JAMA Internal Medicine* Jan 25, 2016, and CM Jones. NIDA Webinar 9/1/2015. Based on IMS Health National Prescription Audit (extracted 8/24/2015) Retrieved from http://www.drugabuse.gov/news-events/meetings-events/2015/09/latest-prescription-trends-controlled-prescription-drugs.

13

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 :*



- ***33-39% of those with active opioid prescriptions during follow-up also were prescribed benzodiazepines.***

Larochelle et al. *Ann Intern Med*. 2016;164(1):1-9.

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**

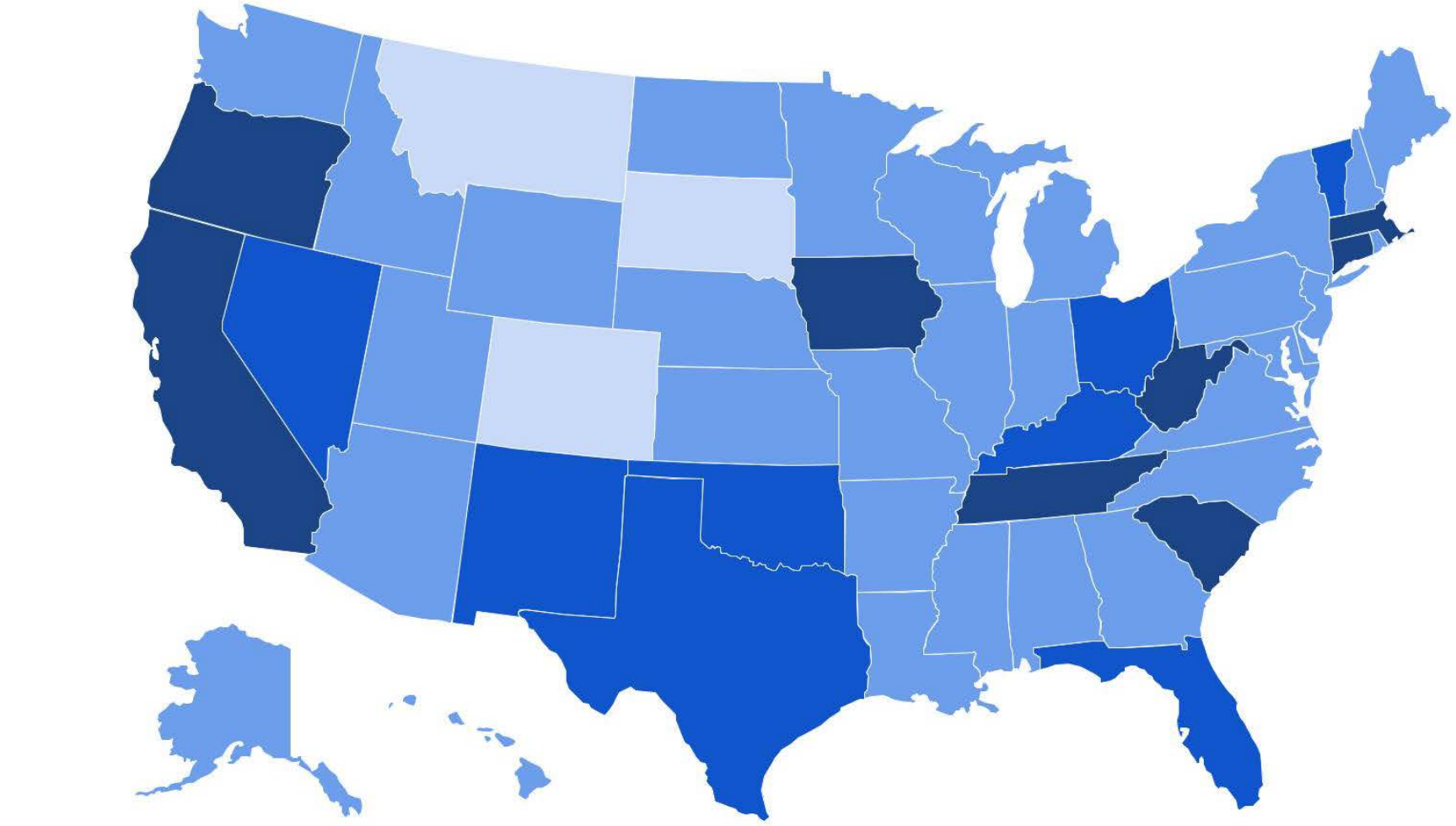
http://www.cdc.gov/washington/testimony/2015/t20150501.htm

- **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*



Source: FSMB CME Overview 2015 at https://www.fsmb.org/policy/advocacy-policy/

Direct *Overdose Intervention*

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

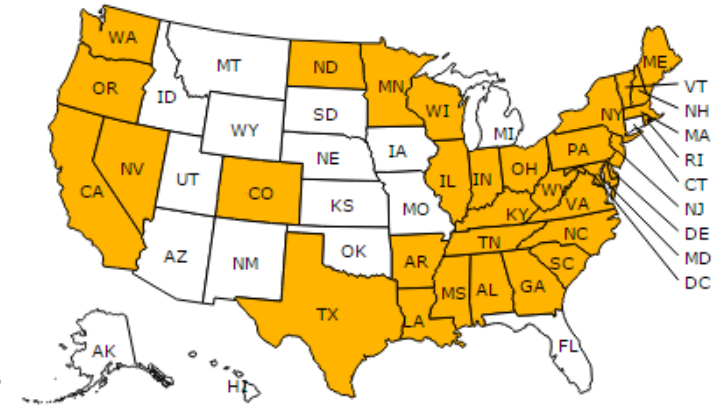
- ***Evzio auto-injector APPROVED by FDA, April 3, 2014***

Naloxone Nasal Spray Development

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

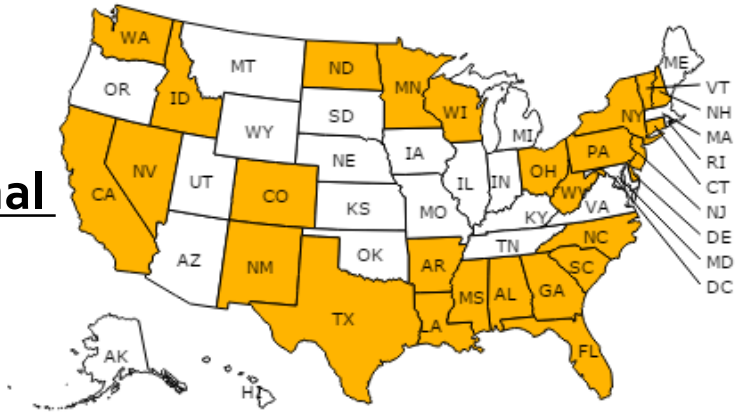
- ***NARCAN nasal spray APPROVED by FDA, November 18, 2015***

Variation in *State Naloxone and Good Samaritan Laws* As of February 1,2016



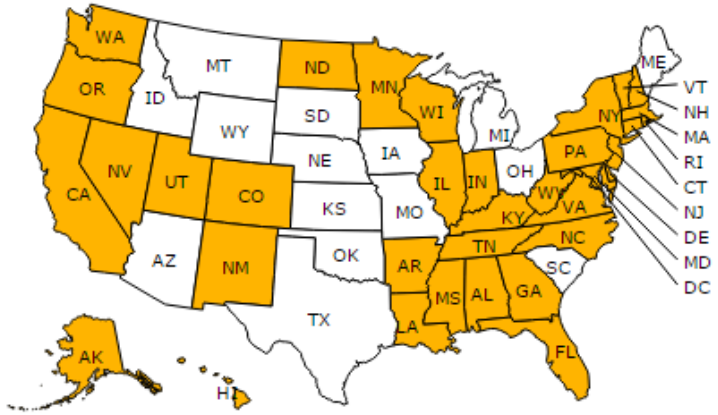
Prescription By Standing Order Authorized

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



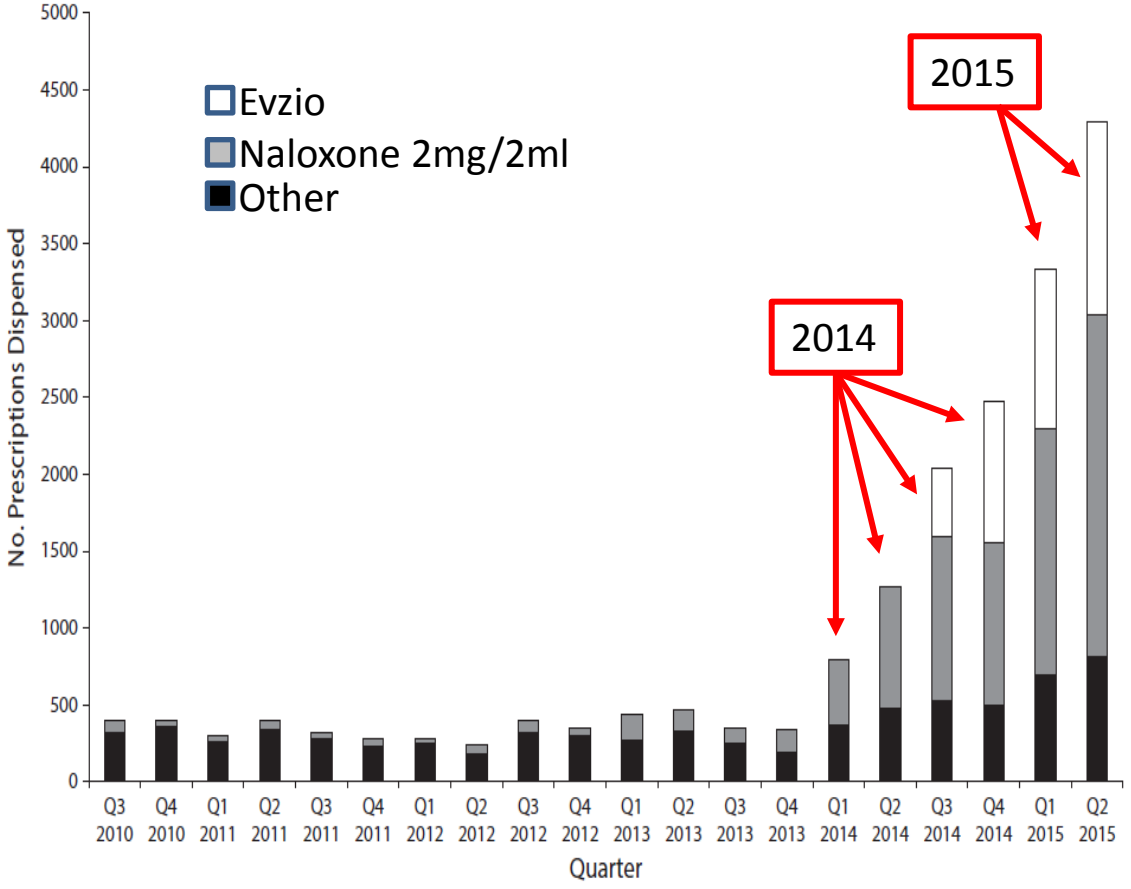
Good Samaritan Overdose Prevention Law

36 states offer legal protections to those who call 911 to report an overdose

PDAPS Prescription Drug Abuse Policy System

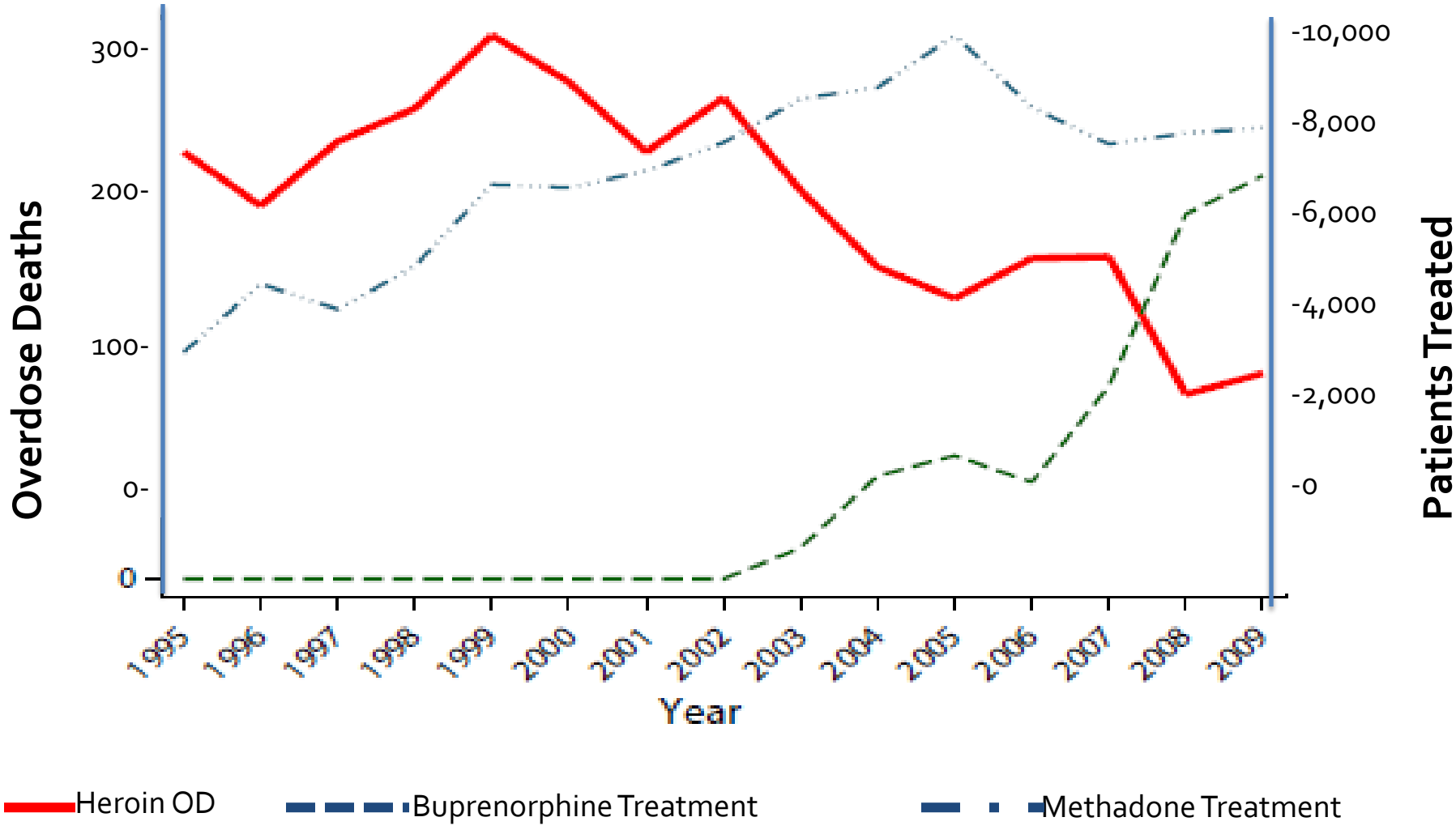
Retail Pharmacy *Prescriptions for Naloxone* Increase Markedly

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



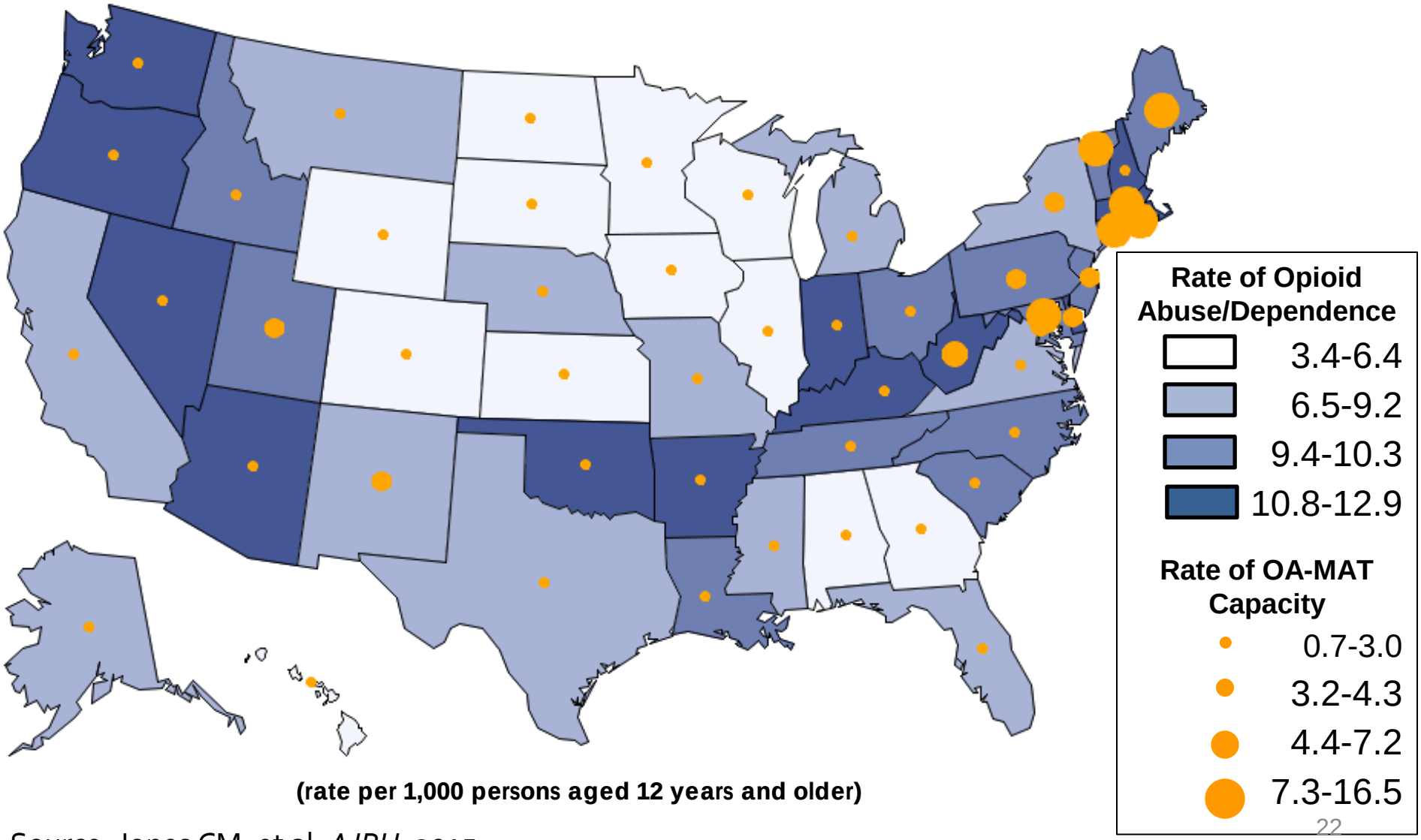
Jones CM, Lurie PG, Compton WM. *American Journal of Public Health* 2016;106(4):689-690

Medical Treatment May Reduce Deaths



R Schwartz et al. *American Journal of Public Health* 2013

Additional Challenge: *Lack of medication-assisted treatment capacity*



(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 waivered physicians practicing in traditionally-underserved areas compared with the rest of the US

Sources: LaBelle CT, et al. *J Subs Abuse Treat* 2015., and Komaromy, M. et al. *Substance Abuse* 2016

State-level policy interventions track with improved outcomes

New York

75% ↓

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

50% ↓

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

36% ↓

2012 Action:

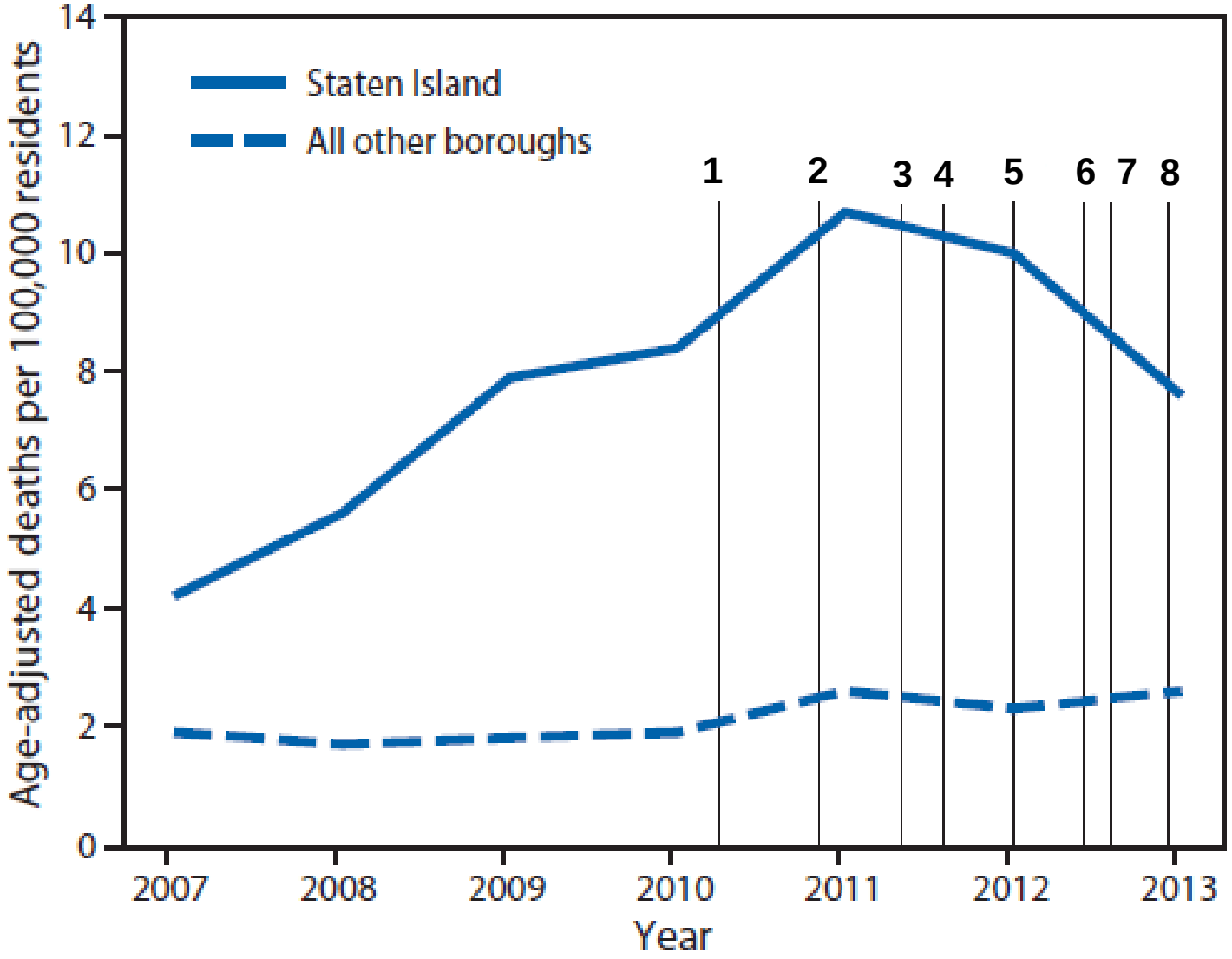
Tennessee required prescribers to check the state's prescription drug monitoring program before prescribing painkillers.

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.

3 SOURCES: NY, TN: PDMP Center of Excellence at Brandeis University, 2014. FL: Vital Signs Morbidity and Mortality Weekly Report, July 1, 2014.

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

CVS pharmacy · RITE AID PHARMACY · AMA · ADA American Dental Association® · NBA · MAJOR LEAGUE BASEBALL · abc · The New York Times · Google

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*

www.drugabuse.gov

Science = Solutions

NIDAMED

Opioid Prescribing:
Safe Practice, Changing Lives

CO*RE:
Report from the Front Lines

Collaborative for
REMS Education

May 3, 2016

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

Representing 750,000+ Prescribing Clinicians

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

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

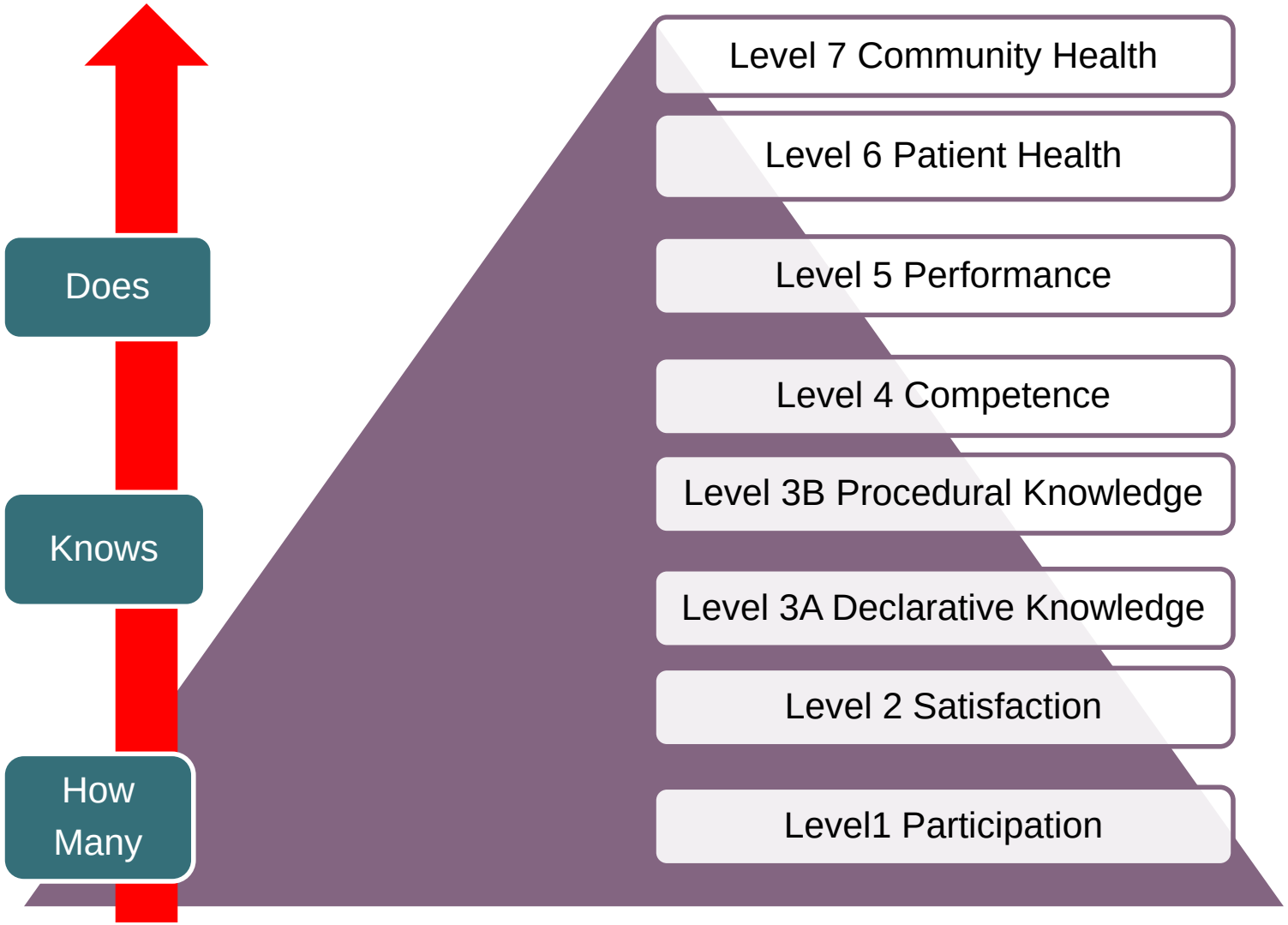
Accredited Education:

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

Typical CE/CME and ER/LA Opioid

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

Moore's Levels of Outcomes



REACH as of 2/28/16

	# of Activities	Learners	Completers	Prescribers Actual
Total Grants	526	135,433*	87,402	28,857

*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

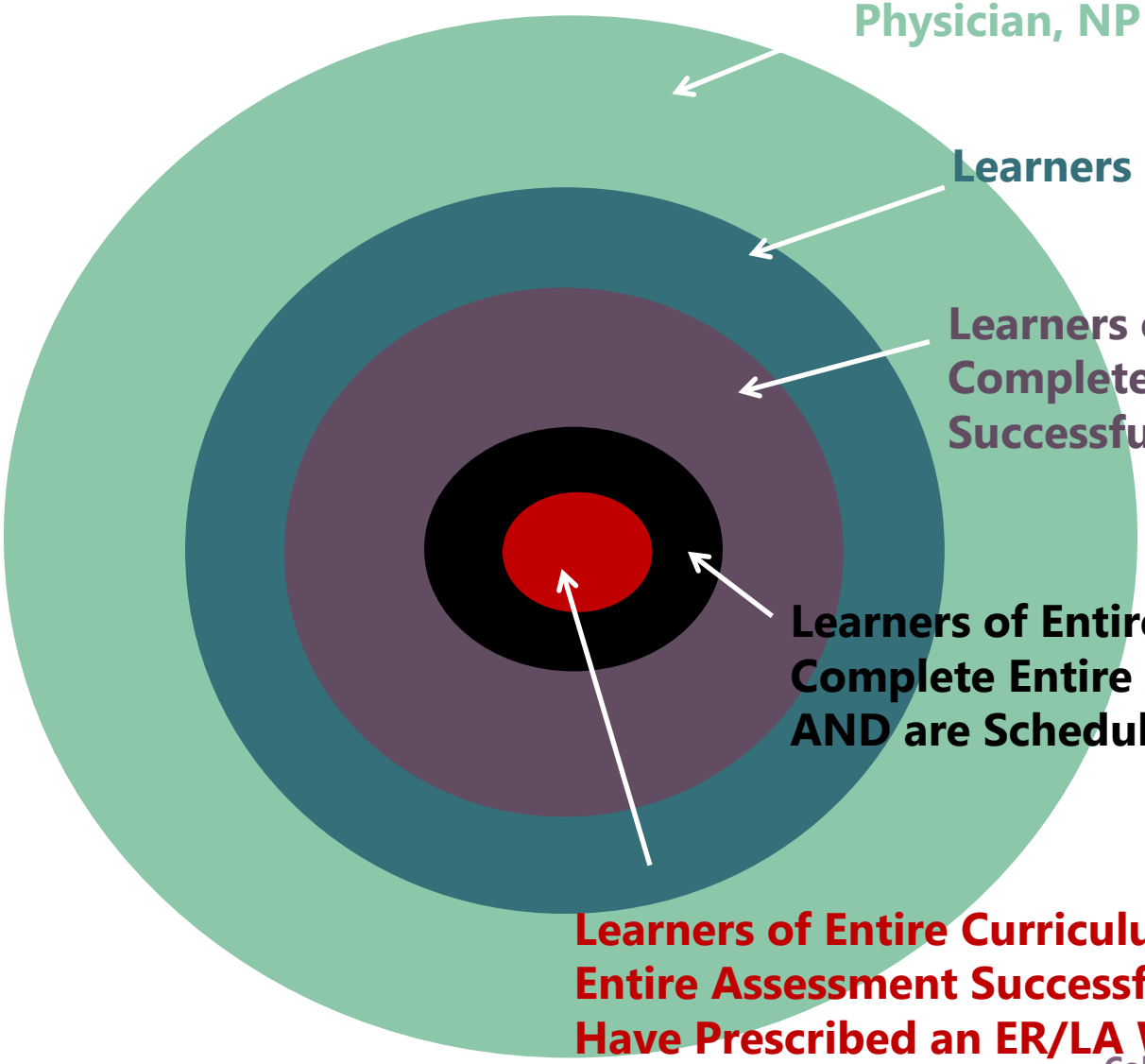
LEARNERS

In 3 Years

By Comparison to Other Acknowledged Successful CE/CME Collaborations

CS2Day / 5 Years	**60,000**
Team A / 4 Years	76,200

"Learner Definition" Driven CE/CME…



Physician, NP and PA Learners

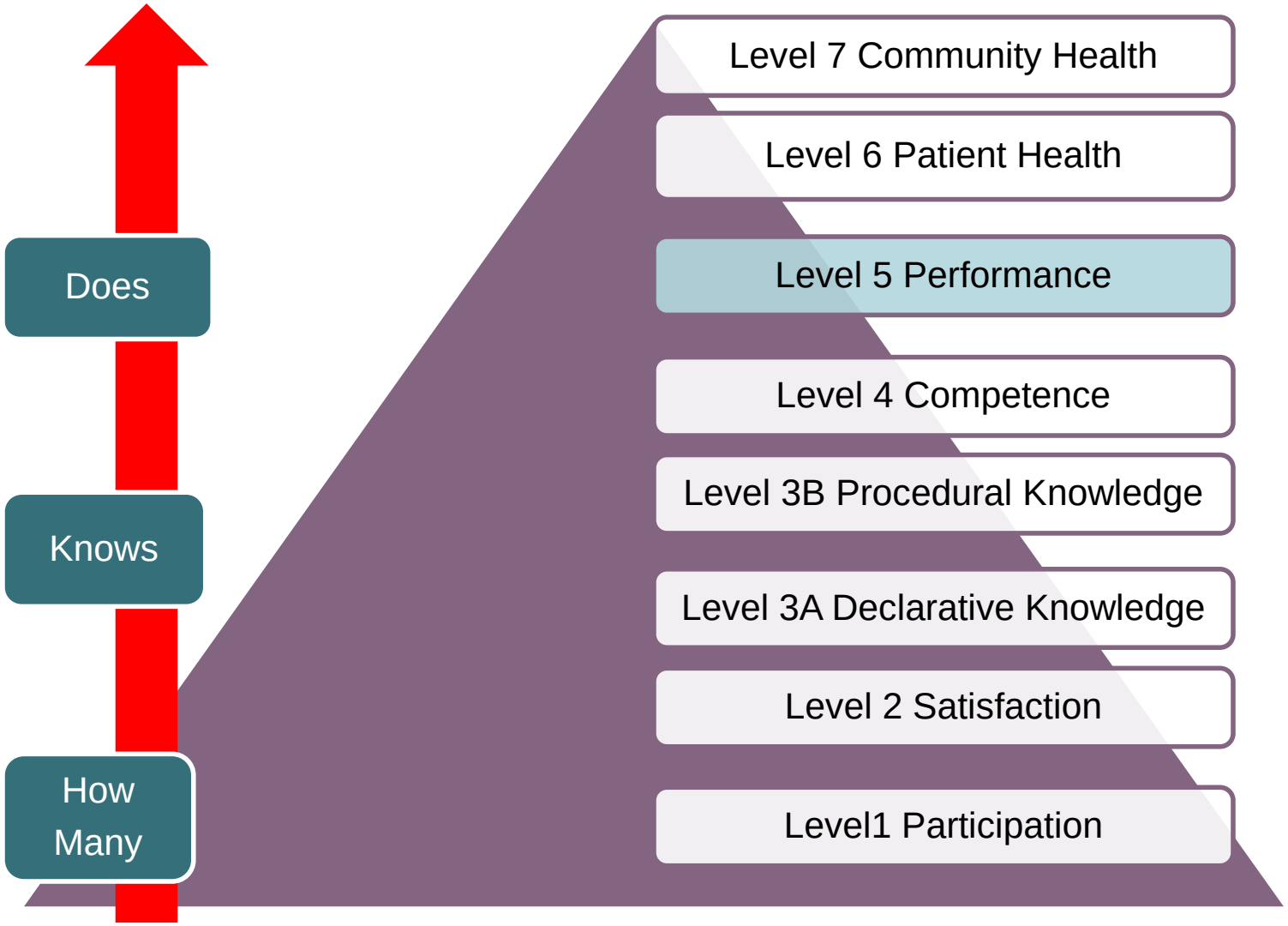
Learners of Entire Curriculum

Learners of Entire Curriculum Who Complete Entire Assessment Successfully

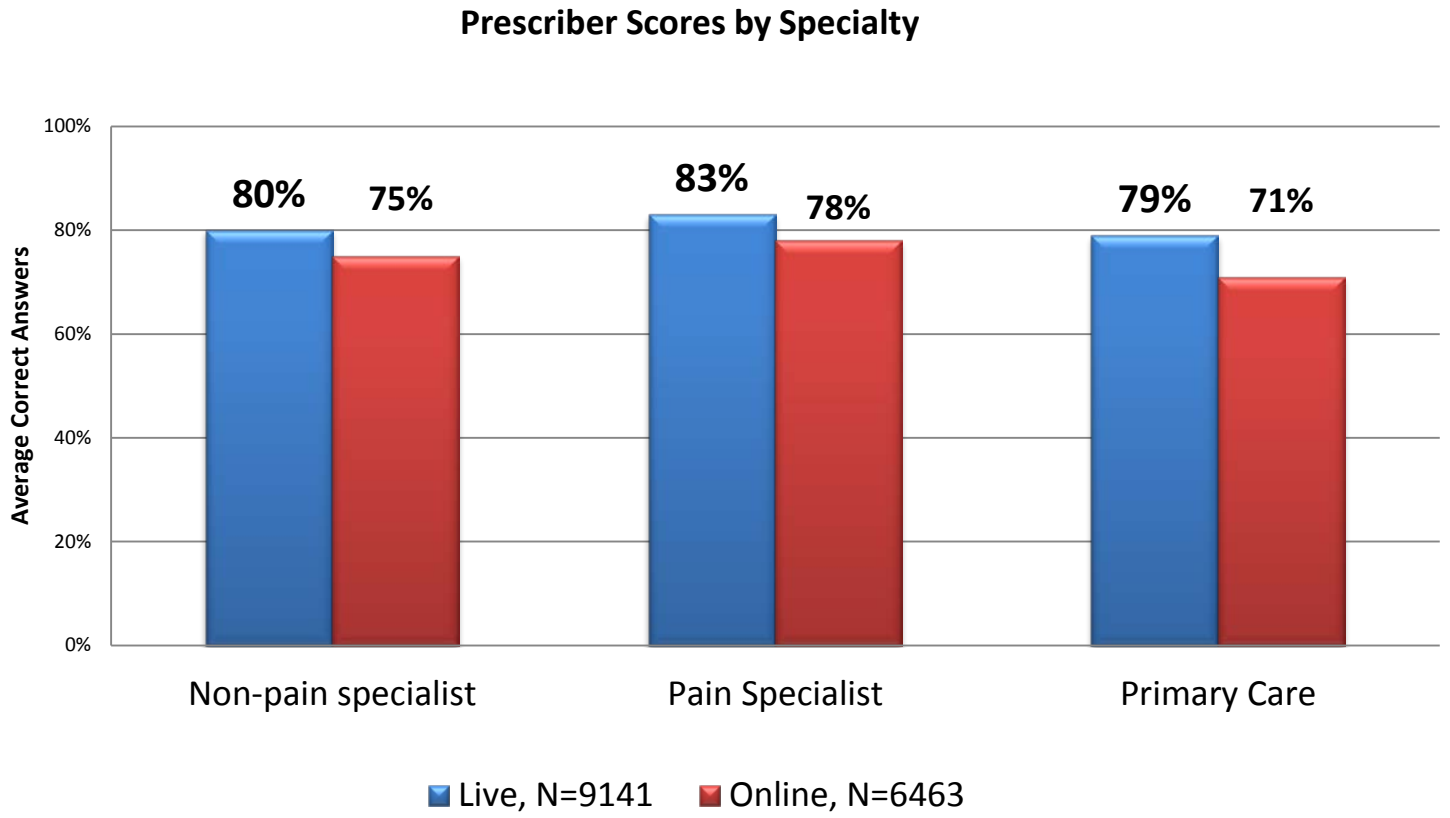
Learners of Entire Curriculum Who Complete Entire Assessment Successfully AND are Schedule II and III Prescribers

Learners of Entire Curriculum Who Complete Entire Assessment Successfully AND Have Prescribed an ER/LA Within the Past Year

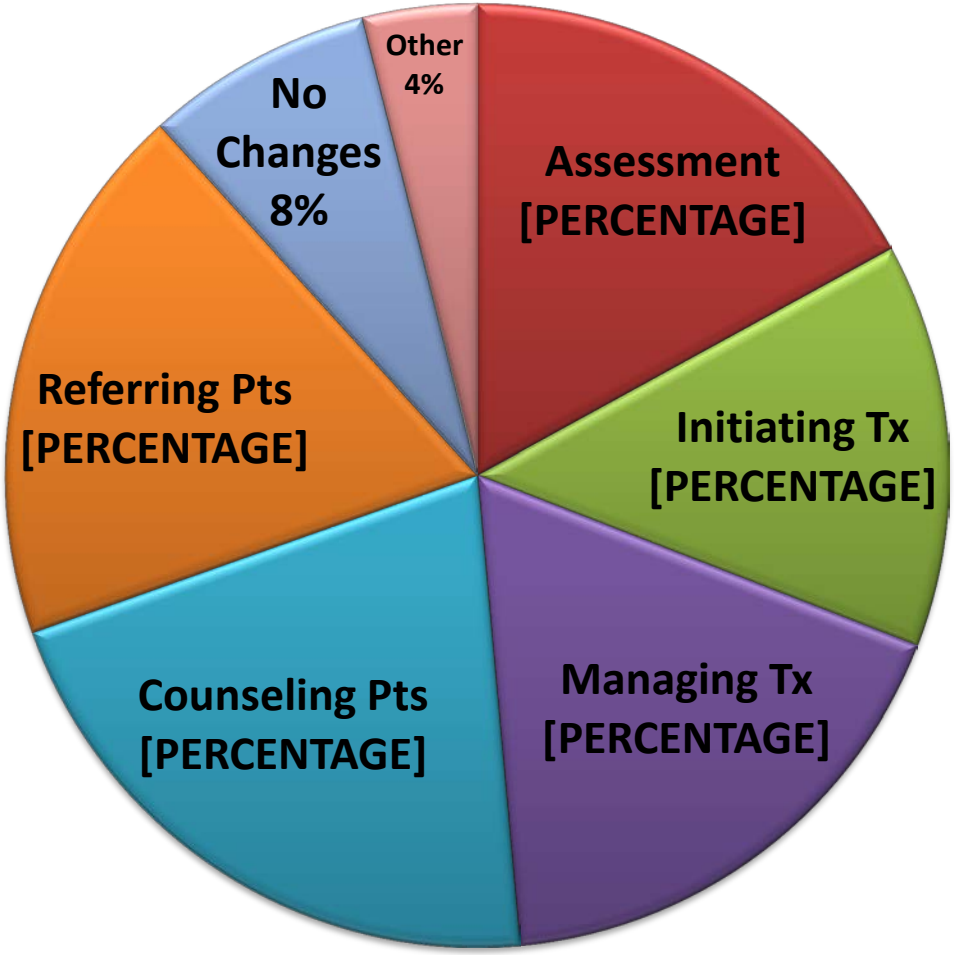
Moore's Levels of Outcomes



Success – Level 3 Knowledge Assessment Scores



Success – Level 5 Performance Implemented Changes in Practice



Additionally, We Are Reaching Learners Who Are Prescribing ER/LA AND IR/SA Opioids

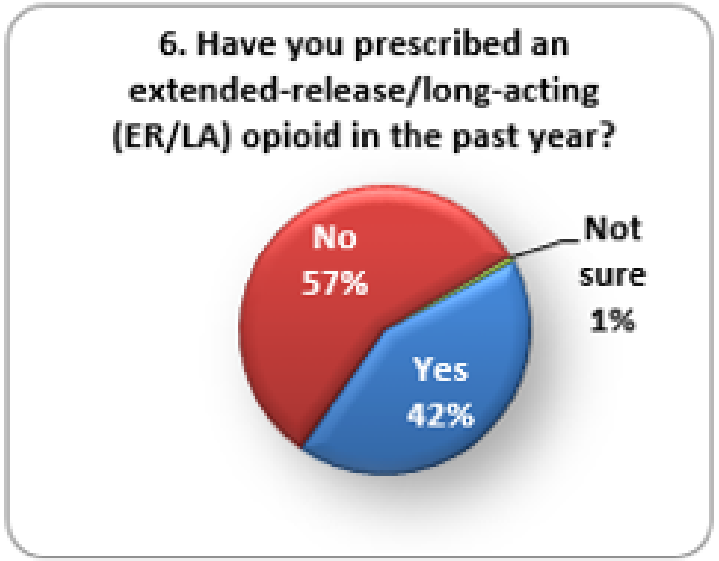
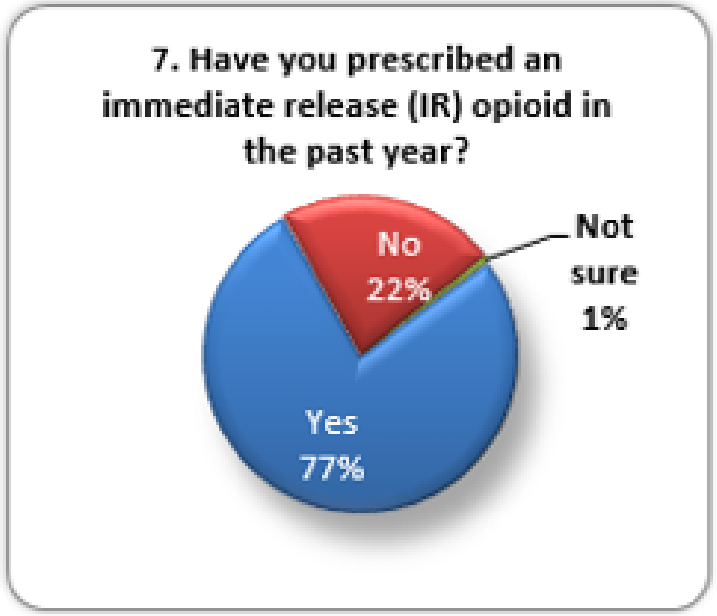


Figure 3



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

PainEDU REMS

Montefiore Inspired Medicine

THE UNIVERSITY HOSPITAL FOR EINSTEIN

Albert Einstein College of Medicine

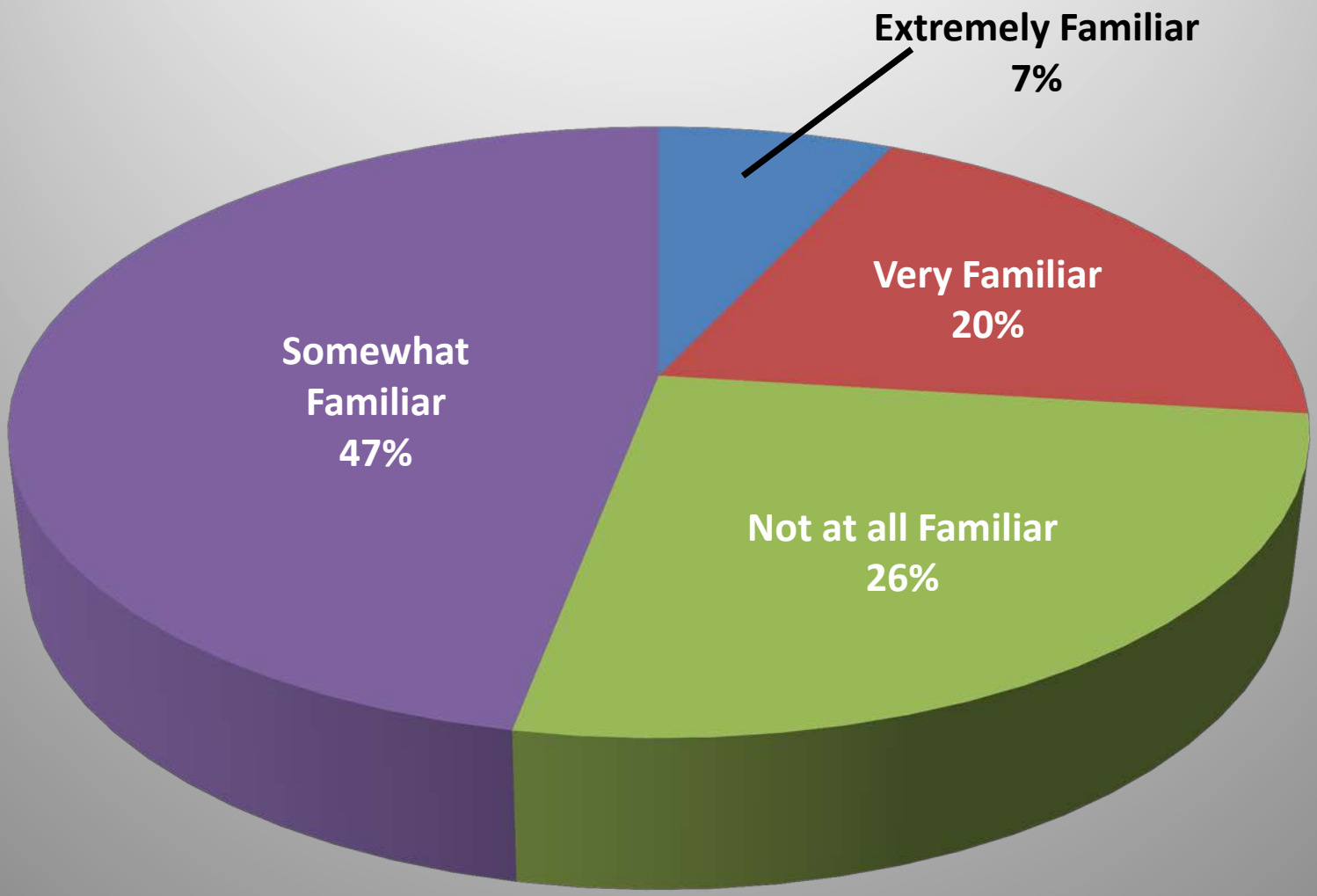
Initial Thoughts

- **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**

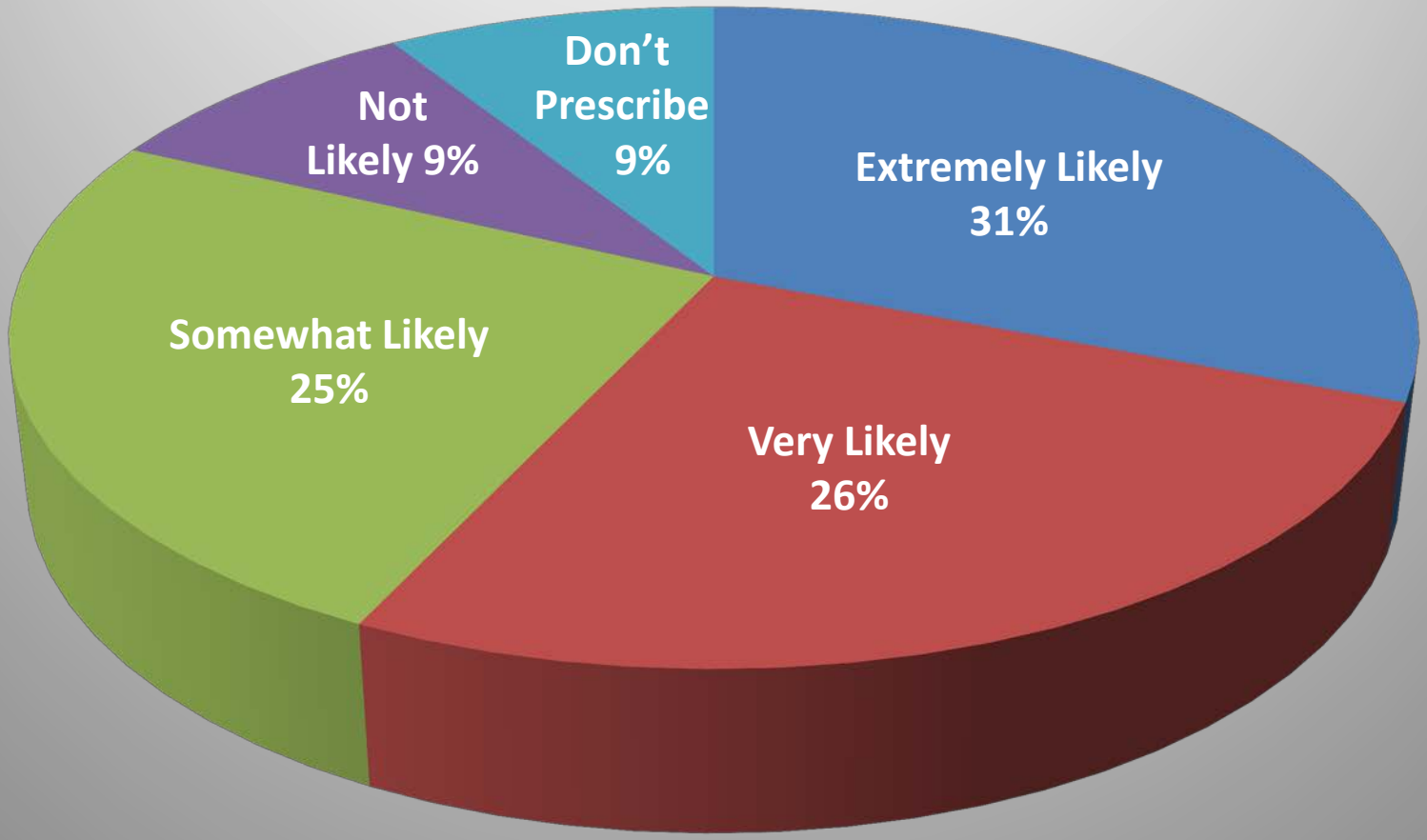
Preliminary Survey

- **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**

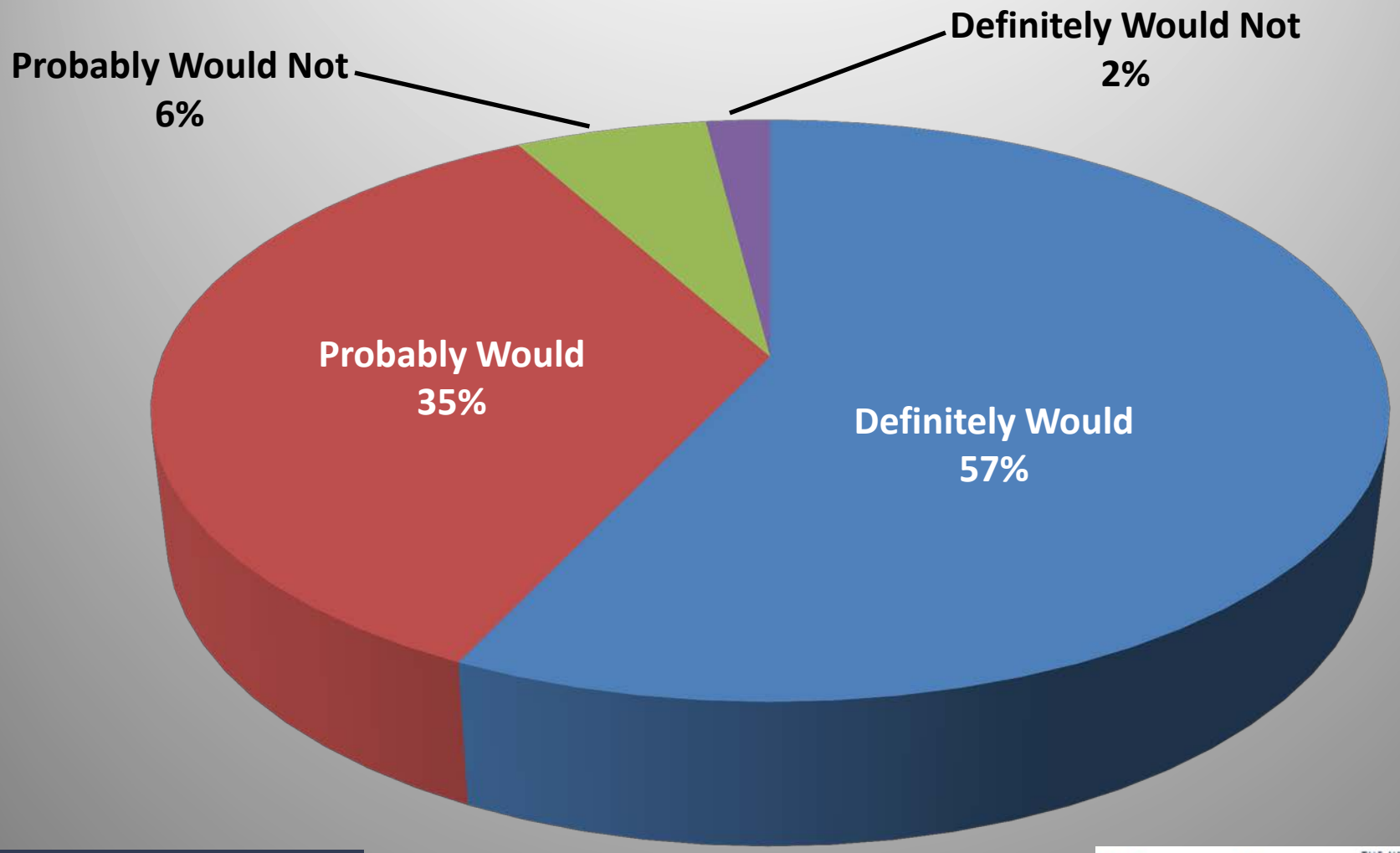
Familiarity with ER/LA Opioid REMS



Likelihood of Prescribing ER/LA Opioids for Moderate to Severe Chronic Pain



Likelihood of Participating in a Voluntary ER/LA Opioid REMS Course



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[1]**
  - Expert
  - Non-expert
- **Many good candidates for education beyond prescribers**
  - Nurses
  - Pharmacists
  - Clinicians in training
  - Prescribers of IR/SA opioid analgesics

1. Chiauzzi E, Trudeau KJ, Zacharoff K, Bond K. Identifying primary care skills and competencies in opioid risk management. *J Continuing Education of Health Professionals*. 2011 Fall;31(4):231-40.

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

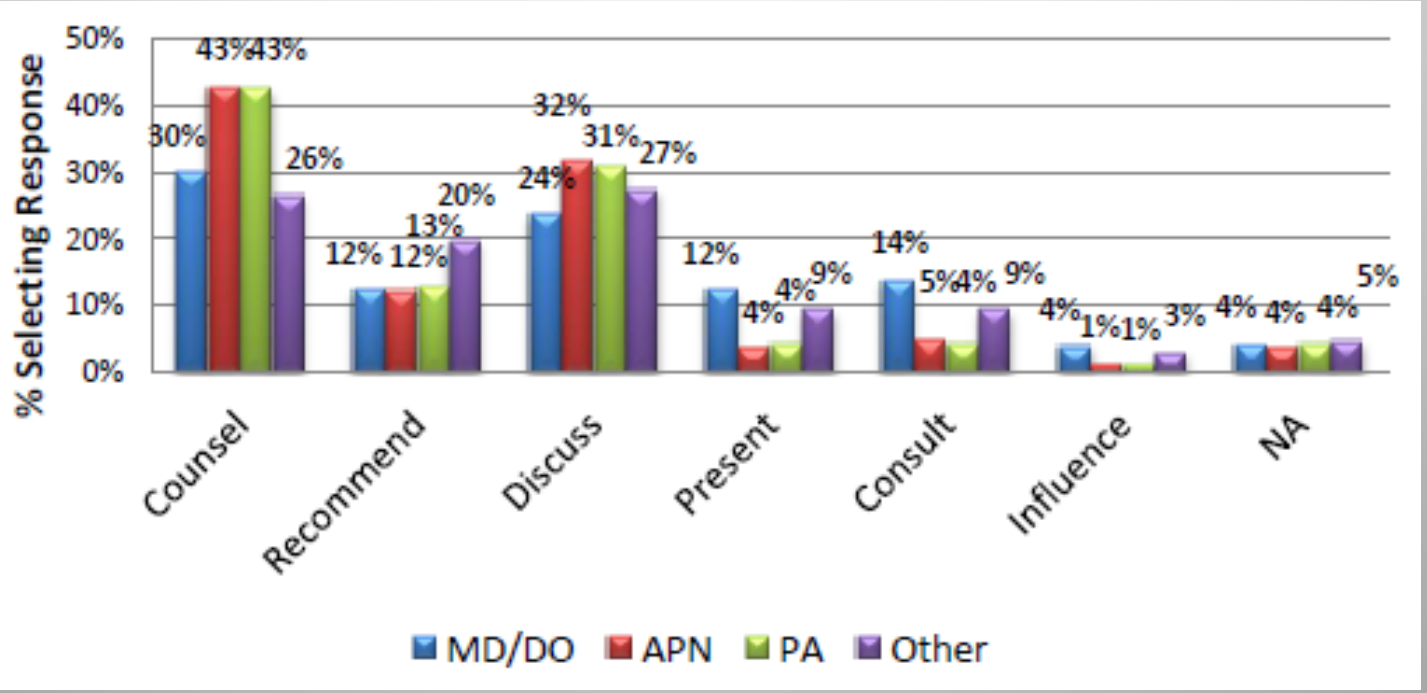
EVALUATION	%
Common Challenges with Chronic Pain	
Psychological complexity of patients	**68%**
Poor patient adherence/satisfaction	**50%**
Time constraints	**42%**
Common Challenges with Opioid Therapy	
Subjectivity of pain/severity	**45%**
Pressure from patients for opioids	**39%**
Difficulty predicting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

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[1]

1. Chiauzzi E, Trudeau KJ, Zacharoff K, Bond K. Identifying primary care skills and competencies in opioid risk management. *J Continuing Education of Health Professionals*. 2011 Fall;31(4):231-40.

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

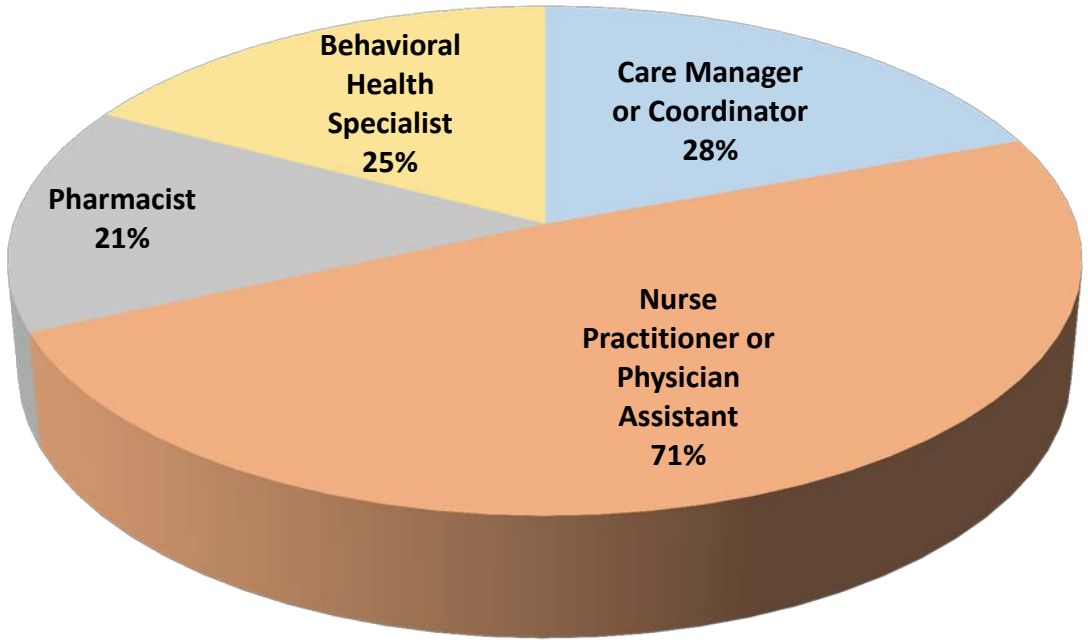
- Quantity educated
  - >647 activities
  - >200,000 educated
  - >167,947 completed education (ACCME PARS)
  - Prescribers and practice team members
  - Tailored to audience (rural NP vs oncologist vs dentist)

Healthcare is delivered in teams.

Practice Characteristics

2,000 patients in panel

Staff at Primary Location



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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

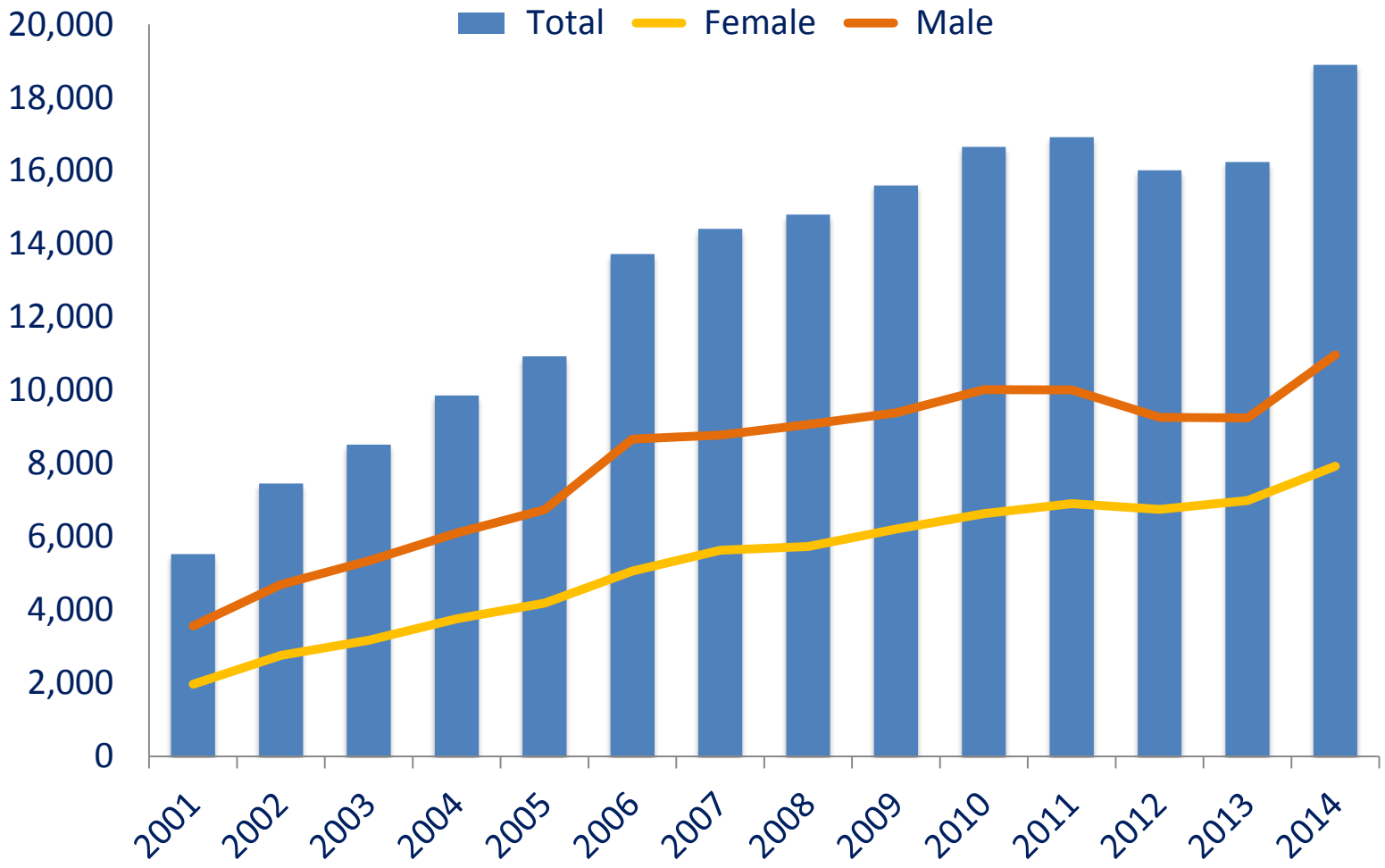
Alignment of Federal Agencies

- FDA
- DEA
- ONDCP
- HHS
- CDC
- Surgeon General
- SAMHSA
- NIDA
- HRSA

National Institute on Drug Abuse

National Overdose Deaths

Number of Deaths from Prescription Opioid Pain Relievers

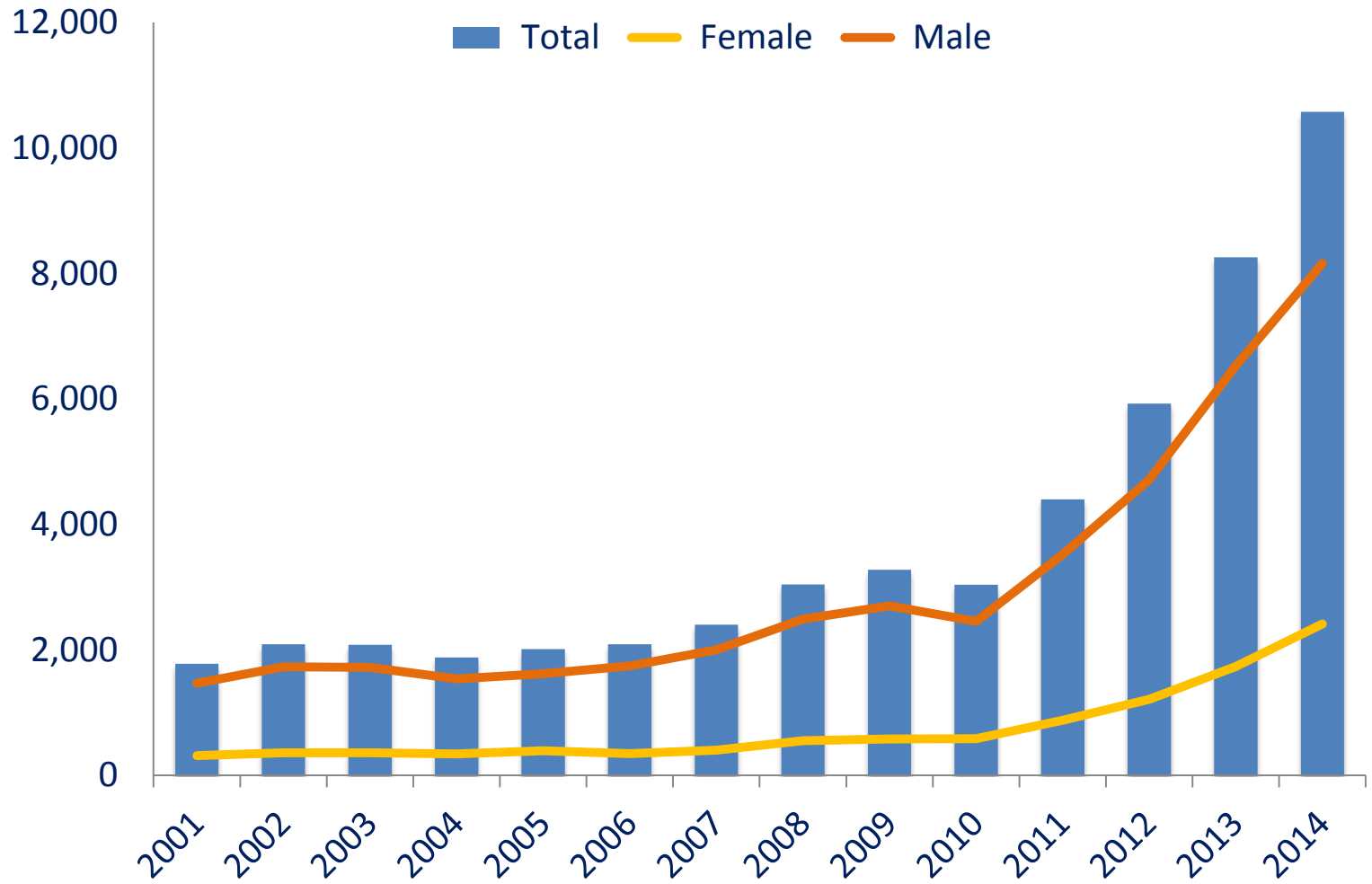


Source: National Center for Health Statistics, CDC Wonder

National Institute on Drug Abuse

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 CRISES OF CHRONIC PAIN AND ADDICTION

Joanna G. Katzman, MD, MSPH

Associate Professor

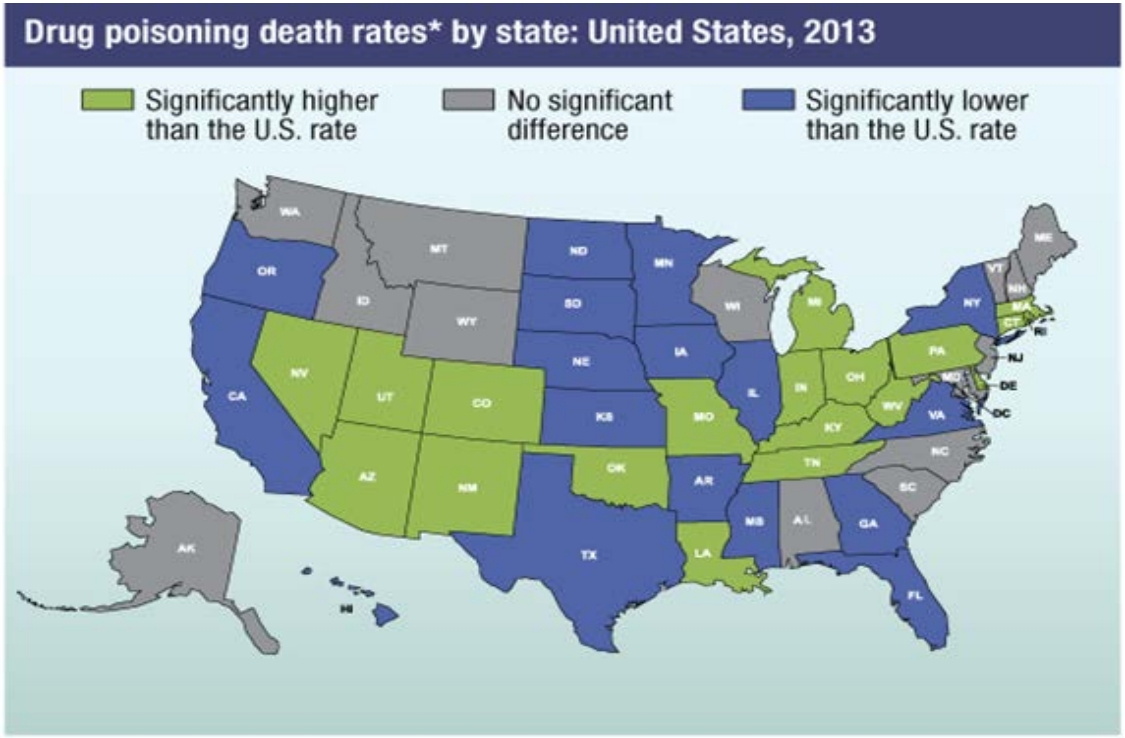
University of New Mexico

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.
- + Source: National Vital Statistics System, 2013.

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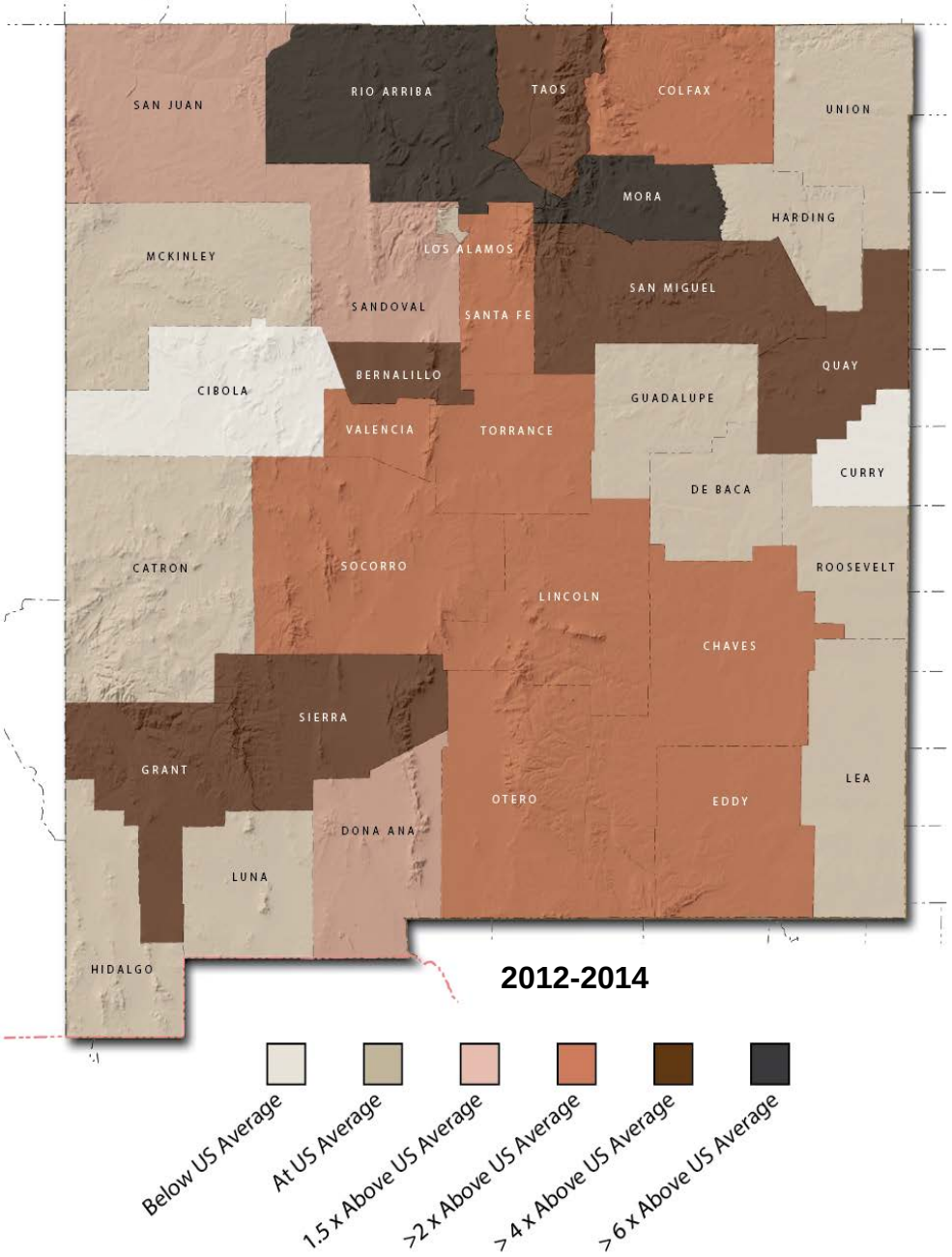
NEW MEXICO- PRESCRIPTION DRUG AND HEROIN OVERDOSE

- 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



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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

NEW MEXICO MEDICAL BOARD 16.10.14 MANAGEMENT OF PAIN WITH CONTROLLED SUBSTANCES

- 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

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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*

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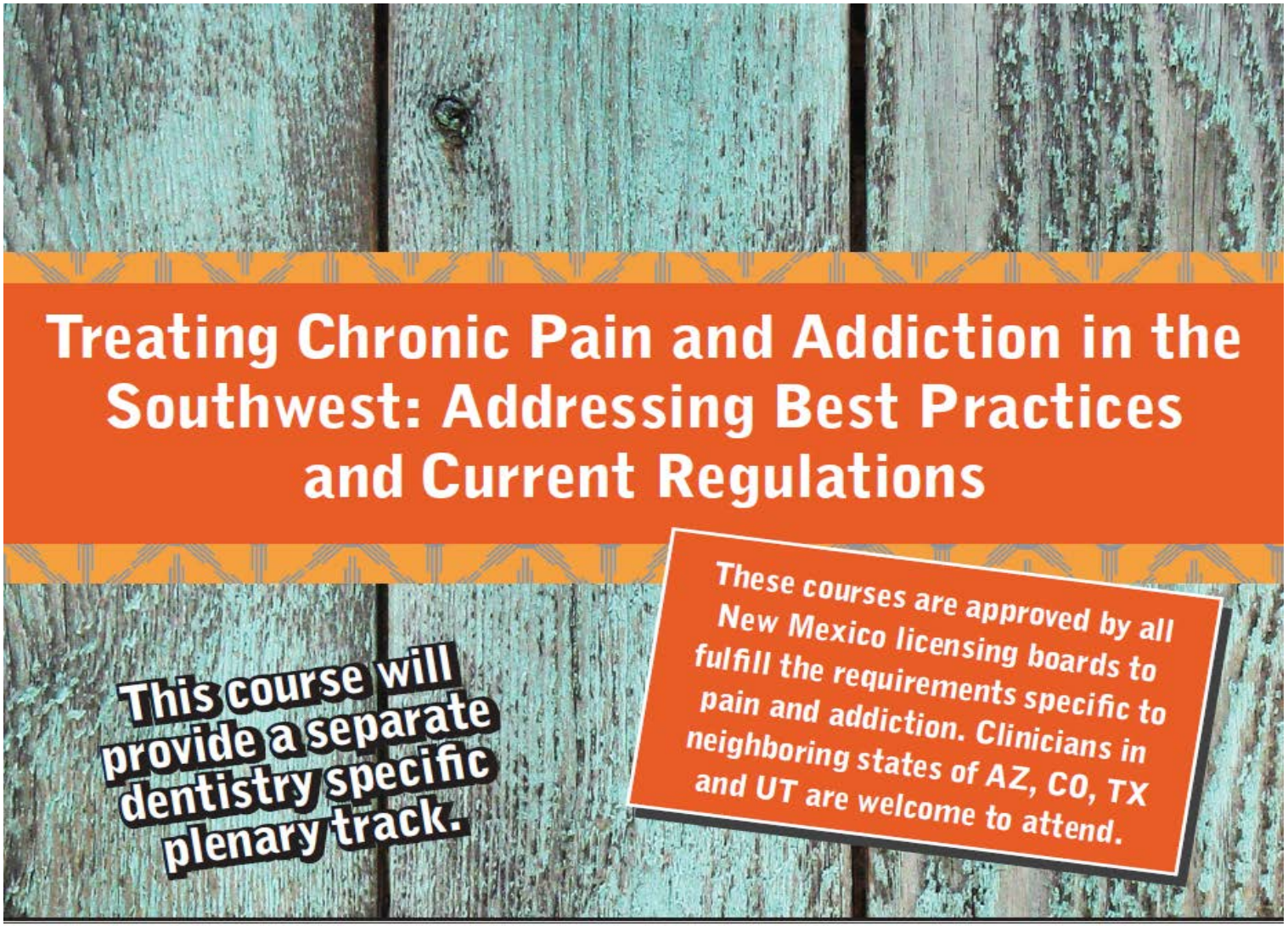
NEW MEXICO MEDICAL BOARD- 2012

- 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



Presented by:

Project ECHO

UNM SCHOOL of MEDICINE

UNM Pain Consultation & Treatment Center
Department of Neurosurgery

M
NCES
CENTER

UNIVERSITY OF NEW MEXICO PAIN COURSES

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:

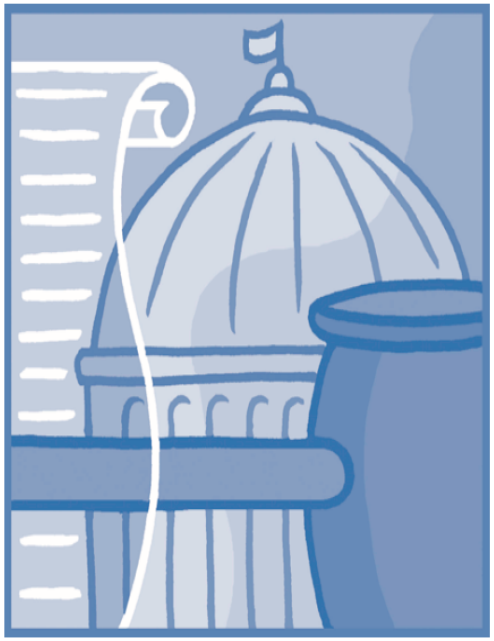
1. Safe(r) Opioid prescribing
2. Management of the patient who is misusing opioids
3. Pediatric/Adolescent Pain
4. Pain and Psychiatric co-morbidities

*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



GOVERNMENT, LAW, AND PUBLIC HEALTH PRACTICE

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,

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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

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Table 2: Chronic Pain One Day Survey Summary

Chronic Pain Knowledge Survey

Measure	Pre Mean	Post Mean	Difference					
			n	Mean	SD	Student's t	P-value	Effect Size(d)
Test Score (10 Possible)	7.04	8.78	1075	1.74	1.68	34.01	<0.0001	1.04
Percent Score (100% possible)	70.4%	87.8%	1075	17.4%	16.8%	34.01	<0.0001	1.04

Chronic Pain Self-Efficacy

Measure	Pre Mean	Post Mean	Difference					
			n	Mean	SD	Student's t	P-value	Effect Size(d)
Overall Rating (7 Possible)	4.56	5.47	1073	0.91	0.85	34.80	<0.0001	1.06
Percent Rating (100% possible)	65.2%	78.1%	1073	12.9%	12.2%	34.80	<0.0001	1.06

Know-Pain 12 Survey

Overall Rating: Tests for Significance

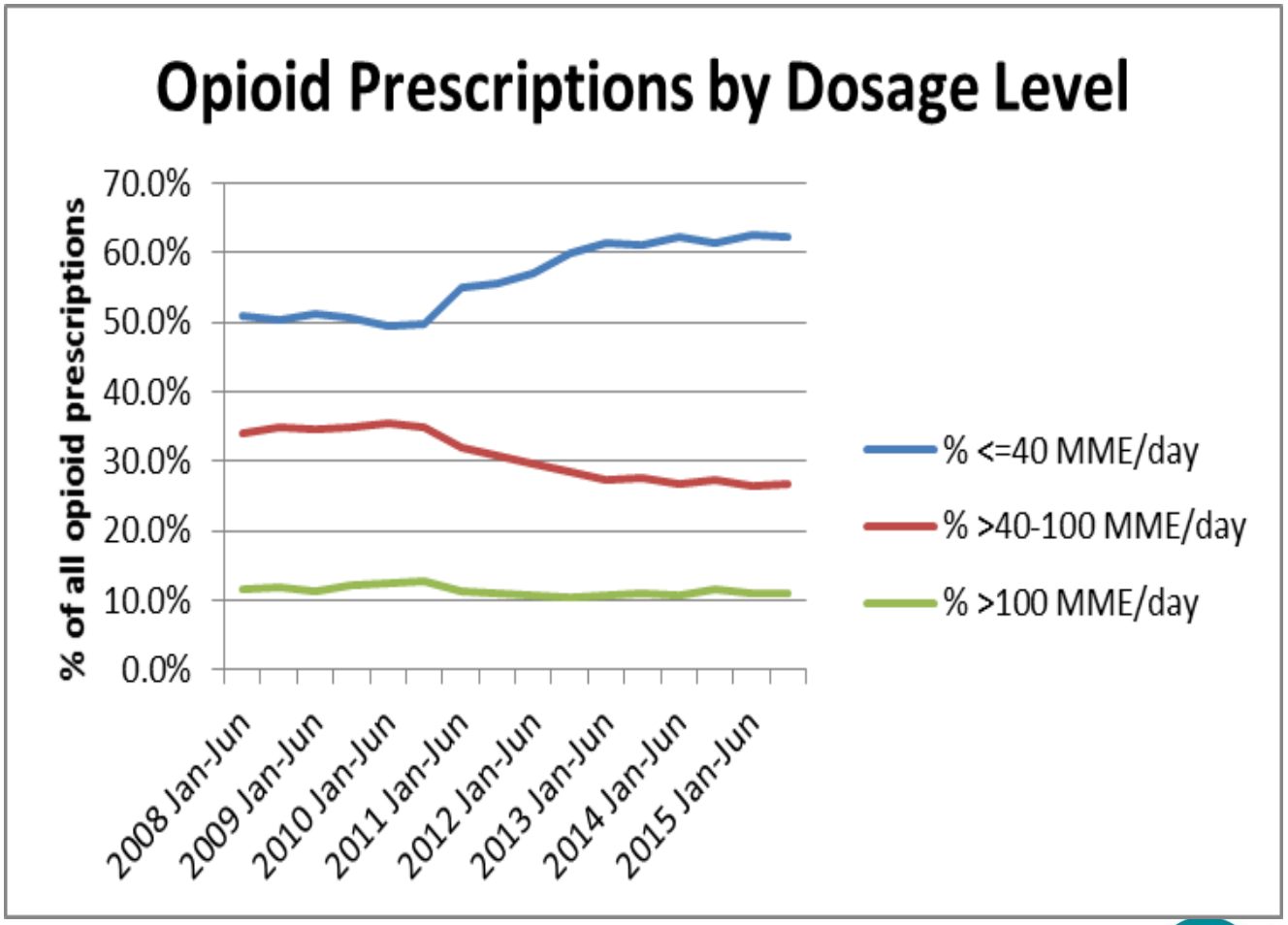
Note: Scores were adjusted to be unidirectional for the overall analysis, with the higher number being the ideal direction of improvement.

Measure	Pre Mean	Post Mean	Difference					
			n	Mean	SD	Student's t	P-value	Effect Size(d)
Overall Rating (6 Possible)	4.23	4.66	1052	0.44	0.39	35.63	<0.0001	1.10
Percent Rating (100% possible)	70.5%	77.8%	1052	7.3%	6.6%	35.63	<0.0001	1.10

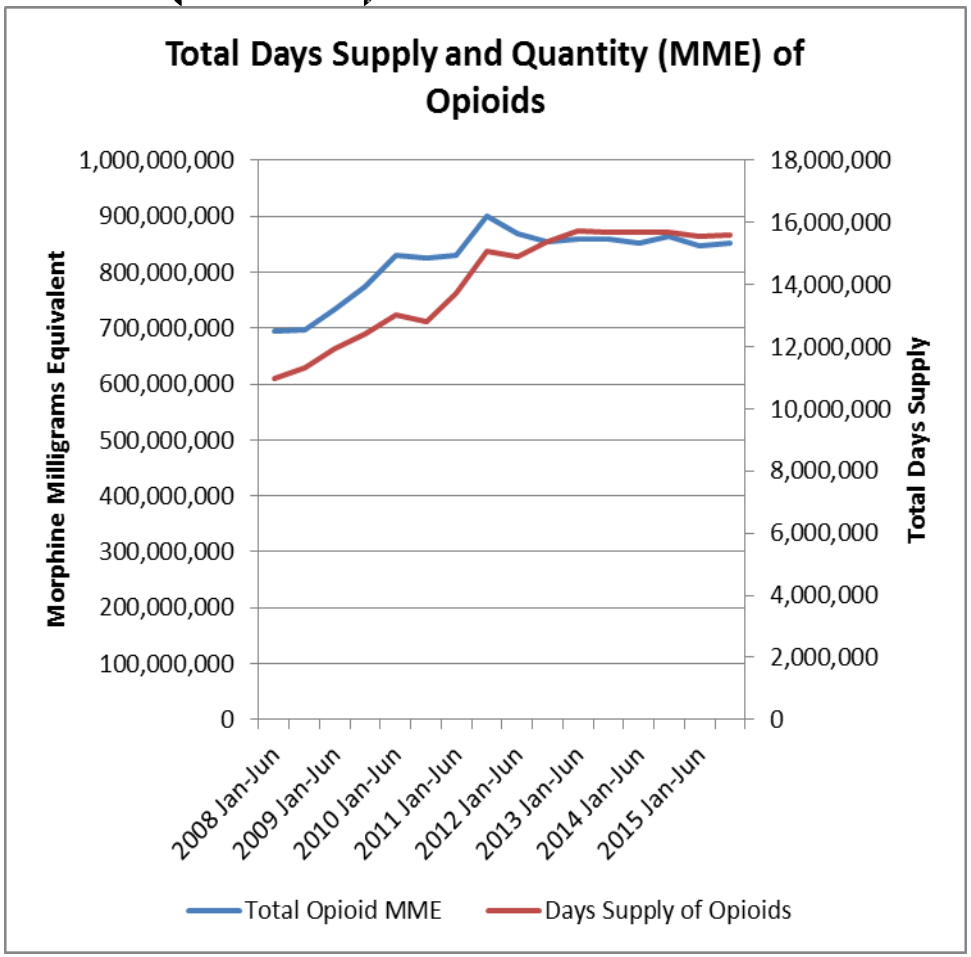
TABLE 3: Prescriptions of Opioid Analgesics and Benzodiazepines from NM PMP Data

Time Period	Opioid Prescriptions Filled	Total MME of Opioids Dispensed	Opioid MME per prescription	Benzodiazepine Prescriptions Filled	Total VME of Benzodiazepines Dispensed
2008 Jan-Jun	748,518	835,798,584	1,117	330,192	208,790,533
2008 Jul-Dec	748,716	838,432,412	1,120	334,092	215,025,059
2009 Jan-Jun	782,970	872,458,043	1,114	352,051	230,144,820
2009 Jul-Dec	783,379	920,667,804	1,175	355,856	234,702,614
2010 Jan-Jun	803,663	980,218,843	1,220	366,773	247,186,367
2010 Jul-Dec	778,050	985,578,313	1,267	351,687	243,520,952
2011 Jan-Jun	809,523	972,977,485	1,202	355,233	247,584,917
2011 Jul-Dec	880,838	1,039,292,508	1,180	380,106	263,125,880
2012 Jan-Jun	863,768	998,153,444	1,156	365,219	252,794,005
2012 Jul-Dec	886,416	969,522,667	1,094	362,415	250,480,873
2013 Jan-Jun	896,925	926,180,808	1,033	358,570	229,931,101

OPIOID PRESCRIPTIONS 2008-2015



TOTAL DAYS SUPPLY AND QUANTITY (MME) OF OPIOIDS



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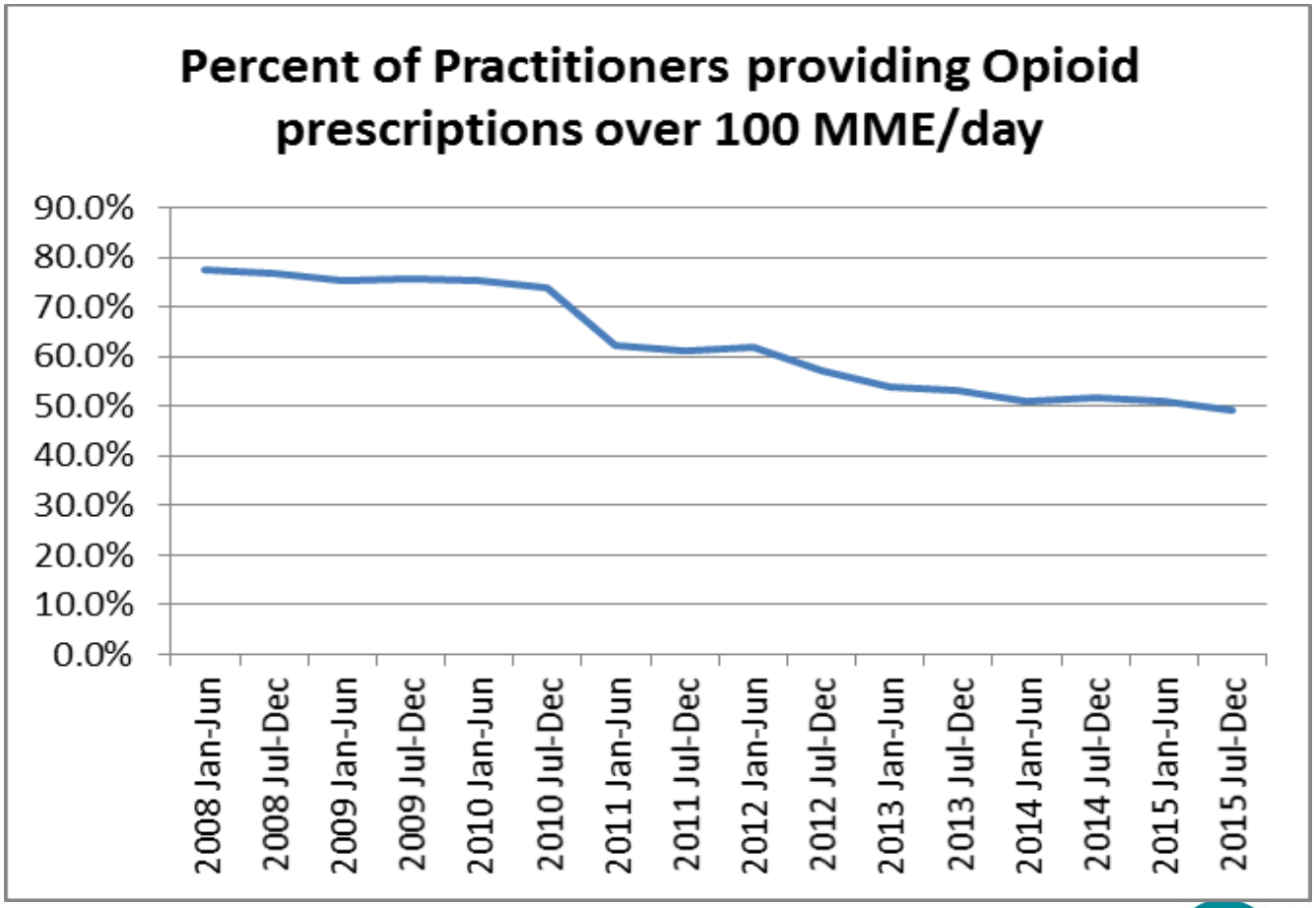
PERCENT OF CLINICIANS PROVIDING OPIOID PRESCRIPTIONS OVER 100 MME/DAY



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NEW MEXICO
DRUG OVERDOSE DEATHS

Year	Number of Deaths
2008	513
2009	428
2010	468
2011	521
2012	486
2013	449
2014	*540

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

- Katzman, JG, Comerci, G, Landen M, et al. Rules and values: a coordinated regulatory and educational approach to the public health crises of chronic pain and addiction, Am J Public Health. 2014 Aug, 104 (8):1356-62.
- New Mexico Department of Health, Division of Epidemiology (James Davis, PhD, Michael Landen, MD)
- Harris JM, Fulginiti JV, Gordon PR, et al. Know Pain 50: A tool for assessing physician pain management education. Pain Med. 2008; 9(8):542-54.
- Presidential Memorandum: Addressing Prescription Drug Abuse and Heroin Use. Accessed March 25, 2016. http://www.Whitehouse.gov
- Federation of the State Medical Boards. Accessed March 26, 2016. http://www.fsmb.org

Promoting Best Practices and the Public Health with Accredited CE

May 3-4, 2016

Graham McMahon, MD, MMSc
President & CEO
ACCME

American Board
of Medical Specialties

Higher standards. Better care.®

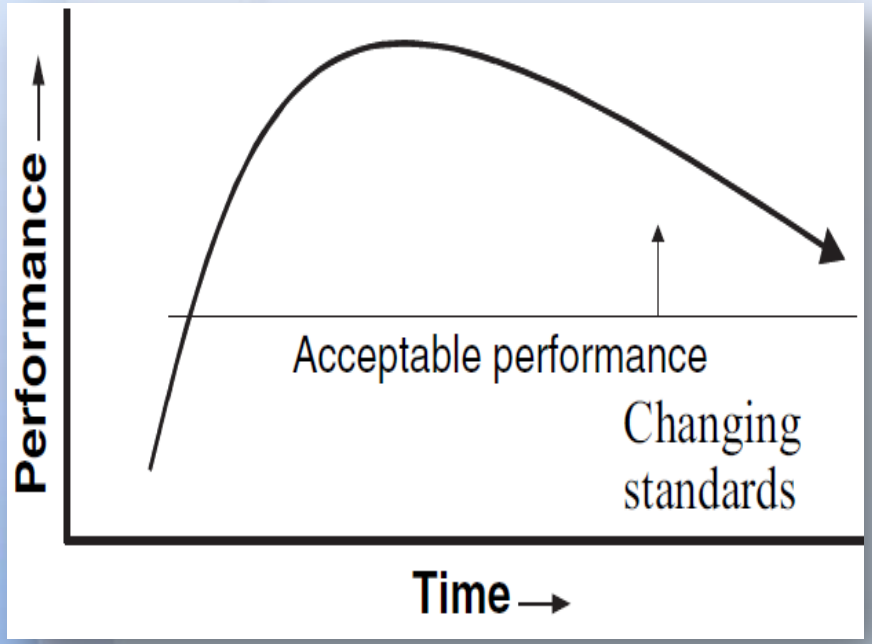
Value of Accredited CE

ACCME

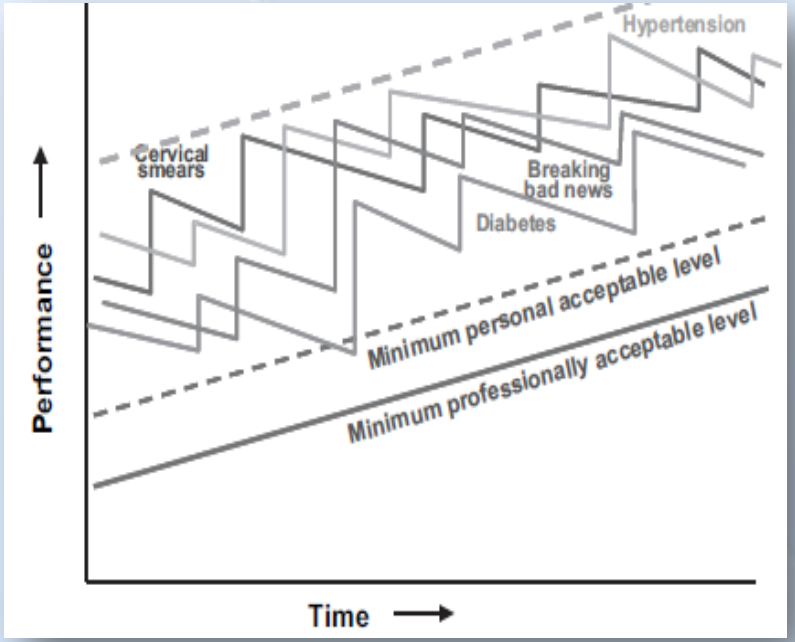
- sets the standards
- performs audits and surveys
- provides clinicians the reassurance that the education they're participating in is:
  - Balanced and evidence-based
  - Designed for relevance: real needs and gaps
  - Evaluated to guide safe, effective care
  - Free of commercial influence

Challenging Assumptions

Ballistic



Trajectory



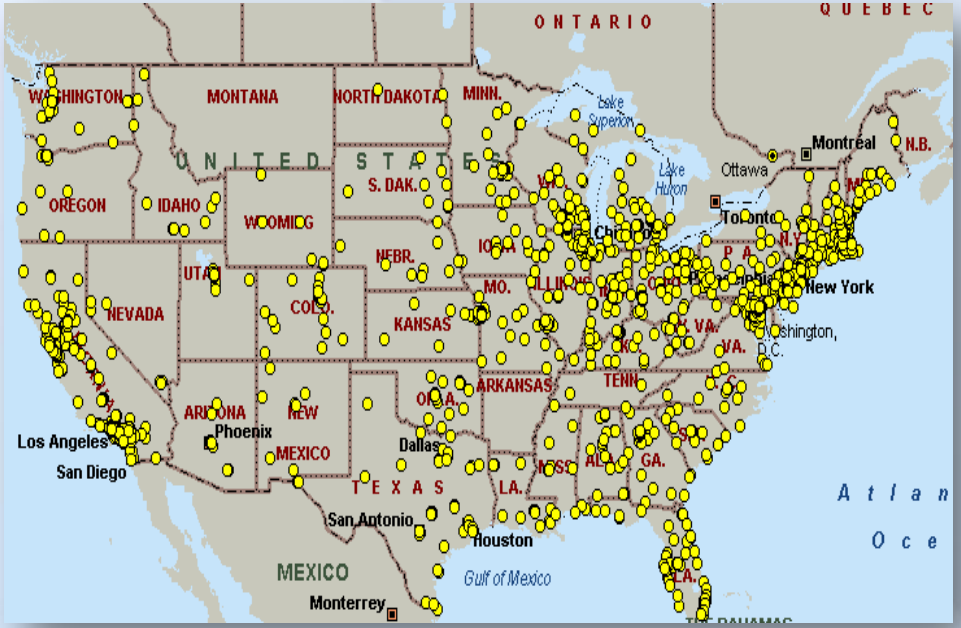
Klass D Academic Medicine 2007; 82 (6)

Scope of the Enterprise

2014 Reporting Year

Physician Interactions	Other Learner Interactions
13,599,687	11,587,518

Activities	Hours of Instruction
147,024	1,033,615



1,908 Accredited Providers

Opioid REMS CME Activities

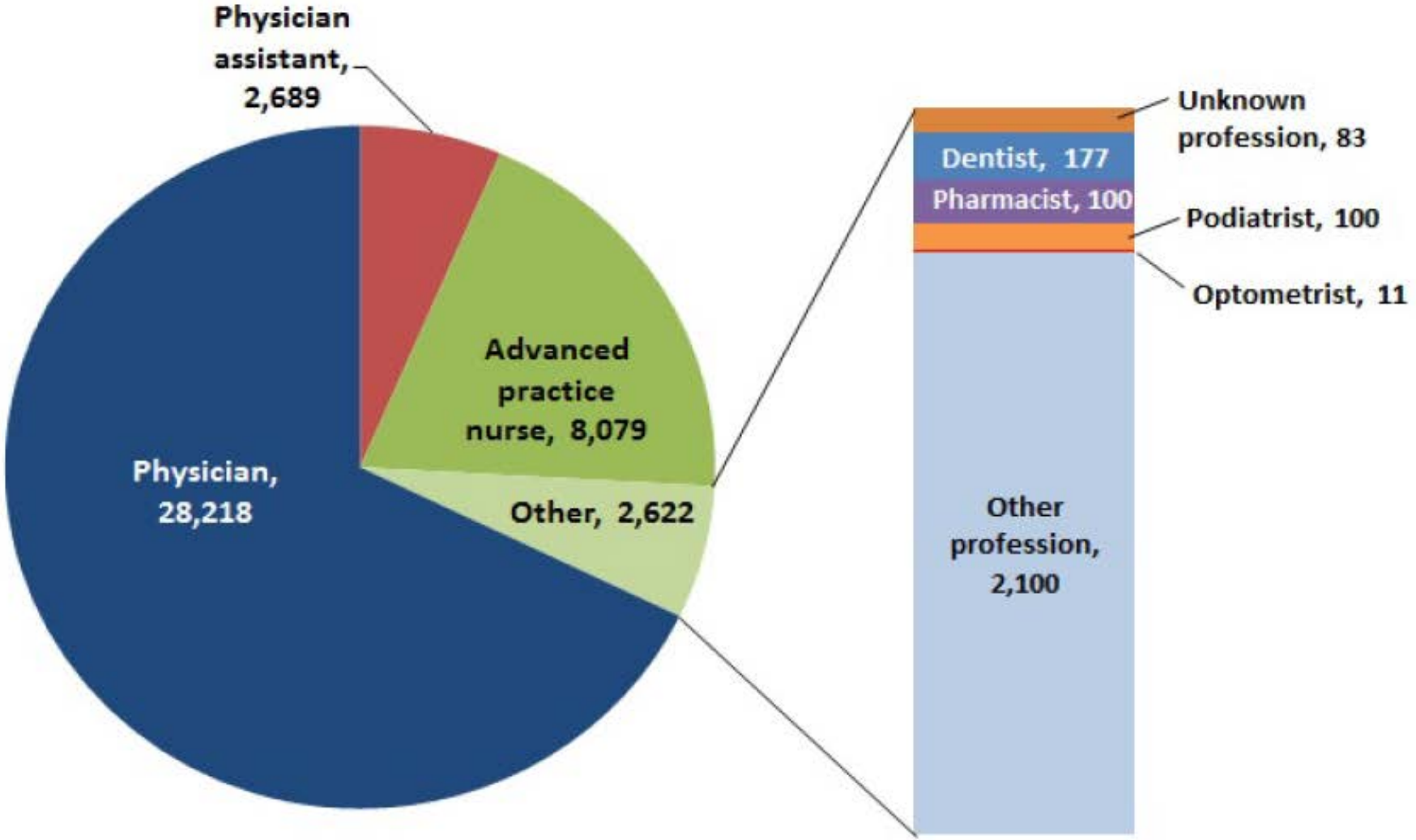
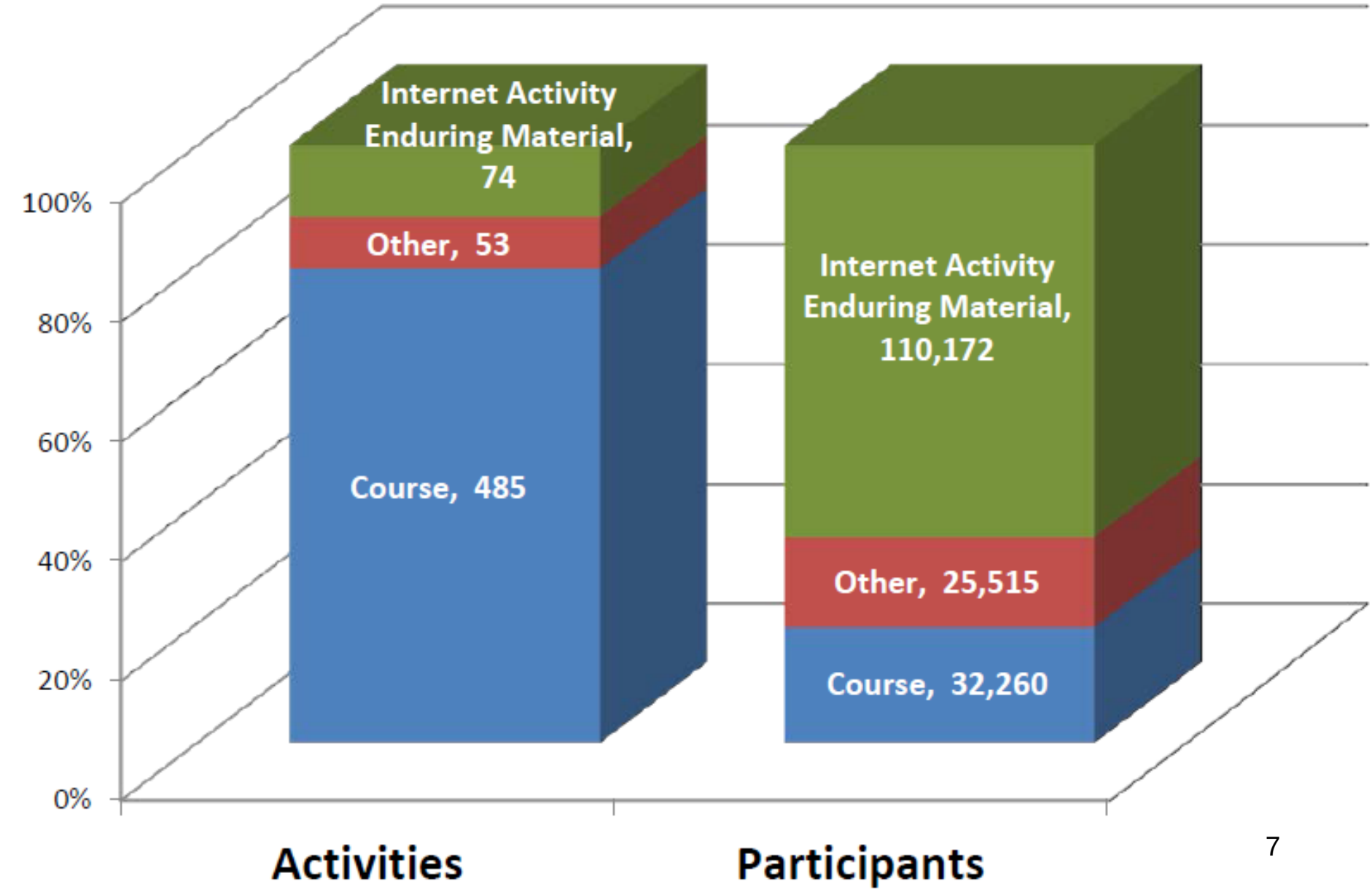


Figure 2: FDA-defined prescribers who have successfully completed ER/LA Opioid REMS-Compliant CE activities, by profession, n=41,608.

Opioid REMS CME Activities



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

Looking Forward

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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Thank you