Opioid epidemic must be addressed from all angles

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Fighting an epidemic requires all groups to work together, and physicians have accepted their responsibility to take action. Physicians, pharmacists, data analysts and policy makers have been working together to reverse the opioid epidemic.

More than 36,000 physicians are now trained and authorized to provide in-office buprenorphine treatment to their patients, Patrice A. Harris, MD, a psychiatrist and chair of the AMA Board of Trustees, said at the 2017 AMA State Legislative Strategy Conference in Amelia, Fla. “Physicians must play a key role all along the continuum, from prevention to intervention and referral to treatment. And, above all, we must address substance-use disorders as brain disorders, as true medical diseases and not a social and moral failing.”

Of the many actions that physicians can take, Dr. Harris said it is important they do a better job of talking with patients about the risks of opioid analgesics, safe storage and disposal and the risk of addiction and dependence and nonopioid pain management. It is also critical to enhance physician education and promote the co-prescribing of naloxone.

“We are encouraging physicians to avoid prescribing opioids to new patients with chronic, noncancer pain,” she said. “Unless the benefits are expected to outweigh the risks and opioids are clinically indicated, we recommend following the CDC guidelines of start low, go slow.”

The AMA’s Task Force to Reduce Opioid Abuse is continuing its efforts to increase education on opioid misuse and ways to prevent it, improve access to naloxone and treatment, reduce the stigma of substance use disorders and encourage registration for, and use of, state prescription drug-monitoring programs (PDMP).

“In 2015, we saw a 40 percent increase compared to the previous year in consultation of state PDMPs,” Dr. Harris said. “That was both in states that had mandatory checking and states that did not. Physicians use these tools when they are user-friendly and have real-time, accurate data.”

The role of regulation

Regulatory changes can have an impact as well. When hydrocodone was moved from Schedule III to Schedule II, the number of prescriptions filled dropped by almost 10,000 per quarter in just two years, according to data presented by Robert Hunkler, director of professional relations at QuintilesIMS.

This regulatory change was estimated to have resulted in 1.1 billion fewer tablets of hydrocodone and combinations being dispensed in the first year after rescheduling than would have otherwise been expected, Hunkler said, citing a March 2016 *JAMA Internal Medicine* research letter.

“When I speak to someone who hasn’t used our information, they often say, ‘If only there were a reliable source of objective information to help me base some policy decisions and gauge the effectiveness of legislation, that would be great,’” Hunkler said. “I just want you to know that IMS could possibly be that source. We are willing and able to work with the state medical societies … we have reliable information to help describe the effectiveness and the effects of legislation regarding opioids.”

Another change that has occurred due to a variety of factors, in addition to increased physician judiciousness, has been a 6.8 percent decrease in opioid prescriptions filled in 2015 from 2014, QuintilesIMS data show. And that decline reaches 10.6 percent over the two-year period between 2013 and 2015.

Looking at the raw numbers is helpful, but cannot tell the entire story of what is changing, Dr. Harris said. “That is a necessary data point, but it’s not a sufficient data point,” she said of the opioid prescribing decline. “What is behind that? What does it mean? Because it could mean that there are patients who need these medications who are not getting these medications … we have to make sure that we are [also] looking at the unintended consequences.”

Naloxone-access laws have made the life-saving opioid overdose antidote available for many overdose victims who would not have survived otherwise. More than 45 states now have naloxone-access laws in place.

“If it were not for that, there would be likely tens of thousands of more Americans who have died from opioid-related overdose,” Dr. Harris said. “[But], in 2015, more than 12 million Americans reported misusing a prescription opioid in the past year. And new data, just released from the CDC, showed that 91 people die every day. The epidemic is far from over.”

“While naloxone has saved tens of thousands of lives, what is often missed in the media coverage of the opioid epidemic, and unfortunately many of the policy recommendations designed to address it, is

the need to attack the problem more comprehensively, more cost-effectively, more humanely," she said.

Frank Dowling, MD, is a clinical associate professor of psychiatry at Stony Brook University School of Medicine and medical director at Long Island Behavioral Medicine, both in New York. Dr. Dowling regularly consults his state PDMP. His home state, New York, mandated PDMP use beginning in 2013. The New York PDMP is fully funded, can be integrated into practice work flow and contains the relevant and timely information that physicians need.

It is a tool to see exactly which prescriptions for controlled substances are being filled for individual patients, Dr. Dowling said. In New York, "doctor shopping" fell 91.2 percent by the end of 2015 since the implementation of the updated state PDMP. The state also saw more than 42,300 PDMP lookups per day, and the number of opioid prescriptions dropped 9.53 percent.

"We've seen a lot of positive impact," Dr. Dowling said, "but we've also seen some worrisome things … a continued increase in opioid overdoses. We warned the state that this would happen if we didn't address addiction as a societal problem as well as a medical problem and really increase access to care. And although there is some increased access, there's still a big gap there in the way society looks at substance use, in my view."

What payers, pharmacies can do

Blue Cross Blue Shield of Massachusetts in 2011 examined their data and found that they had a couple of opportunities to address the epidemic. They looked at people using short- and long-acting pain medications and saw that they could intervene at the beginning of the process.

Their multipronged approach included prior authorization for short-acting opioid after three, seven-day fills within 60 days of the original. New starts of long-acting opioids require prior approval and a block of opioids from mail orders, among others, said Thomas Kowalski, RPh, clinical pharmacy director of health and medical management at BCSC of Massachusetts

The new approach reduced the monthly prescription rate of opioids by 15 percent and decreased the number of patients using prescription opioids by almost 9 percent, or 14,000 fewer opioid prescriptions per month. The effort also cut claims for short-acting opioids by about 25 percent and eliminated an estimated 21.5 million doses of opioid medications in the state over a three year period.