Physicians are fighting on the front lines of the opioid crisis

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Physicians on the front lines of the nation's opioid crisis are writing fewer opioid prescriptions, consulting more often with state prescription drug-monitoring programs (PDMPs) and increasing patients' access to life-saving naloxone and evidence-based treatments.

The number of opioid prescriptions written fell by 55 million between 2013 and 2017, according to the AMA Opioid Task Force 2018 progress report.

The report notes that the number of physicians and other prescribers registered in their state PDMPs has more than tripled in three years to almost 1.55 million in 2017 from less than 472,000 in 2014. PDMP queries also rose 389 percent during the same period.

Prescriptions for the opioid-overdose antidote naloxone more than doubled last year, rising to 8,000 a week. There are also more than 50,000 physicians certified to provide in-office buprenorphine for the treatment of opioid-use disorder, up from less than 38,000 in the previous year.

"While this progress report shows physician leadership and action to help reverse the epidemic, such progress is tempered by the fact that every day, more than 115 people in the United States die from an opioid-related overdose," said AMA President-elect Patrice A. Harris, MD.

New policy calls for better access

The AMA House of Delegates adopted policies at the 2018 AMA Annual Meeting that called for initiating or providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings.

Delegates also called on the AMA to support legislative and other efforts to expand and improve pregnant women's access to evidence-based treatment for substance-use disorders.

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Physicians, however, are not waiting for politicians or policymakers to act. They are initiating their own programs to stem the opioid epidemic.

Grassroots initiatives are blossoming in places where physicians have implemented local solutions tailored to meet the particular needs of their communities.

At the University of Michigan in Ann Arbor, Chad Brummett, MD, has focused on prevention by reducing the risk of opioid naive patients becoming persistent users while cutting the number of excess pills in a community. Dr. Brummett's research has developed evidence demonstrating that patients' post-operative pain can be managed with fewer pills prescribed while not leading to patient discomfort or decreased satisfaction.

"If we give them less, they will take less," Dr. Brummett said. He compared it to people eating more if given a bigger plate with more food on it.

Physicians at the University of Chicago Medicine system are developing a holistic approach that includes customizing care for individual patients, reducing the supply of opioids vulnerable to diversion and increasing access to medication-assisted treatment (MAT), said David Dickerson, MD, former chair of the system's Pain Stewardship Program.

"Patients with chronic pain, anxiety disorders, addiction or opioid dependence require an individualized approach to treatment planning due to the complex biopsychosocial nature of these conditions, but they can still benefit from standardized screening and risk-assessment tools," Dr. Dickerson said.

Creating a complete care ecosystem

At Wareham Pediatric Associates in southeast Massachusetts, a new practice model integrating MAT into pediatric primary care is being tested as an answer to problems that are exacerbated by having too few inpatient treatment beds and not enough pediatric or adolescent medicine physicians specializing in addiction medicine.

Providing MAT is part of the primary care strategy developed by Sharon Levy, MD, director of the Adolescent Substance Abuse Program at Boston Children's Hospital. It is made possible by having prescribers in a practice undergo the eight-hour training course that is required by the Drug Enforcement Administration (DEA) before a health professional can prescribe or dispense buprenorphine.

Since it is often hard to find a substance-use counselor to refer patients to, another component is to have a licensed independent clinical social worker on site in the practice. Social workers maintain independence for billing purposes, but their work is fully integrated into the practice.

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Dr. Levy explained that the idea is not to co-locate a social worker in the practice who then sees patients in parallel to the rest of the staff, but to create a “practice-wide multidisciplinary effort” and “a complete ecosystem for substance-use disorder in pediatric primary care.”

“It’s fully integrated and everyone holds a piece of the puzzle,” said Dr. Levy, who represents the American Academy of Pediatrics on the AMA Opioid Task Force.

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