Governor's Task Force on Prescription Drug and Opioid Abuse

Joint meeting of Education and Treatment Workgroups: Provider Education

May 12, 2015; 9:00am – 11:30 am

Capitol Building, House Room 3

I. Present:

Panel

Carol Forster, MD, Physician Director, Pharmacy & Therapeutics/Medication Safety Mid-Atlantic Permanente Medical Group

Robin Hamill-Ruth, MD, Associate Professor, Anesthesiology and Critical Care Medicine; Director, Clinical Pain Research, University of Virginia Health System

Dan Harrington, MD, Vice President for Academic Affairs for Carilion Clinic

Mary McMasters, MD, FASAM Addictionologist, Comprehensive Behavioral Health

Hughes Melton, MD, VP, Medical Education for NE and NW Markets of Mountain States Health Alliance

Gerard Moeller, MD, Professor of Psychiatry, Pharmacology and Toxicology, and Neurology, Division Chair for Addiction Psychiatry, Director of the Institute for Drug and Alcohol Studies and Director of Addiction Medicine, Virginia Commonwealth University

Kent Norman , EdD, AGPCNP-BC, Nurse Practitioner, Pain SCAN-ECHO McGuire VAMC, Richmond, VA

Treatment Workgroup

Jaime Areizaga-Soto

Duffy Ferguson

Nancy Finch

Cynthia Kirkwood, PharmD

Deputy Secretary Jennifer Lee, M.D.

Mary McMasters, M.D.

Hughes Melton, M.D.

Patricia Shaw

Art Van Zee, M.D.

Education Workgroup

Lisa Wooten

Don Flattery

Danny Saggese

Sarah Melton (co-chair), PharmD.

Terry Dickinson, DDS

John Welch

David Brown, DC

Sterling Ransone, MD

Victoria Cochran (co-chair)

Craig Branch

Jane Chambers

Maria Jankowski

Public attendees: Stephanie Lynch, VAHP

Staff: Jodi Manz, Ralph Orr, Mellie Randall

II. Welcome and Introductions

III. Provider Discussion, frame: addiction and abuse often starts with a prescription. What are the common themes, and how are we teaching our prescribers? How are we ensuring provider best practices? What are we doing well? What are we missing? *Dr. David Brown facilitated*

a. Theme: *Being able to give feedback to prescribers about their prescribing history can change prescribing behavior*. Integrating educational programs that include individual data. Kaiser reduced high volume prescribing by 34% without posing restrictions (Carol Forster). Providers don't want to do harm; if you tell them about potentially problematic prescribing, they will generally self-correct.

b. Theme: *The consistent issue with improper prescriber is simply that at all three levels (med students, residents, practicing physicians) just don't know how to prescribe properly.* Often, prescribers are unaware that they are facilitating addiction because they don't know what to look for or their patients have been inappropriately treated for chronic plain and end up with addictions.

c. Theme: *Resident education is inadequate to train students in proper prescribing*. At most schools, no specific prescribing curriculum exists; at Carillion, each residency has one lecture throughout the year on this. Generally, residents learn from attending physicians and the culture of the clinic. If that culture is not

supportive of proper prescribing or if opioid prescribing is low on the priority list; that alone can undo very successful classroom learning.

d. Theme: *Virginia has a lack of treatment programs to which providers can refer patients clearly experiencing addiction*. When residents and providers encounter addiction, they can stop prescribing, but they don't have the resources to get individuals connected to treatment.

e. Theme: *Difference places and different groups of learners have different needs and solutions.* Reaching students is theoretically easy, but involves a change from outside of government. Med students are bright and eager to learn, but something would have to be bumped in the curriculum. At this point, nurses and veterinarians get more education in pain management than physicians. Residents take direction from the doctors around them, and their education is structured so that the experiential piece may be more influential. There is no standardized education around addiction, prescribing, or treatment, and there is no integrated education for this either. The Accreditation Council of Graduate Medical Education is the accrediting body that would have to make changes. Practicing prescribers are the most important group to reach right now, because they are the folks actively prescribing. Reaching them is a matter of mandating CME (MSV suggests a sunset clause on any mandating language), as well as keeping prescribers accountable.

f. Theme: *Poor prescribing practices may be the result of primary care physicians using opioid narcotics as a primary or only treatment*. The effectiveness of opioids is not nearly as high as assumed; other treatment methods may be more effective and appropriate for pain patients. Opioids are often best used as an adjunct therapy, but alternative treatments are not even taught. It was advised that physicians should begin considering other options for a patient at the very first refill.

g. Theme: *Continuing Medical Education about addiction, proper prescribing, and treatment is the essential piece in stemming the tide of misuse and abuse*. Providers cannot know what they do not know. Recognizing that there are multiple subjects that could be useful to providers is important. Providers must learn to recognize the disease of addiction for what it is and know how to address it. They must also learn about pain management, as primary care physicians are often the providers who handle pain in patients. And further, they must know about treatment resources, particularly when those resources are sparse due to

locality, patient insurance status, or other barriers to treatment. It was also raised that a CME on fraud as it relates to opioids could be very useful.

h. Theme: *Working with insurers can pose challenges to good prescribing practices*. The reimbursement scheme with insurers means that providers often feel pressured to see patients in 15 minute increments, which is insufficient for many. Defining parity in substance abuse treatment has been difficult. And finally, the medications that can be prescribed are limited.

i. Theme: *Providers must be empowered to treat patients in the safest and most appropriate ways*. Some patients have come to expect narcotics when they present with pain. Providers may feel that they are being pressured, passively (through patient satisfaction surveys) or actively (overt requesting of opiates) by patients. This is in itself an option for CME; providers should know how to handle these kinds of conversations.

j. Theme: *The drug is abusing the patient*. Many patients don't know that they're misusing a drug and are often taking it as prescribed. In addition to well-trained prescribers, patients should be educated about how opioids work, their length of treatment, and other treatment options available for pain.

IV. Audience Comment and Questions

V. Composing of Individual workgroup recommendations

VI. Meeting adjourned 12:00 pm; next workgroup meetings TBD