Academic Medical School: Implementing Curriculum in Chronic Pain and Opioid Misuse

Pain, Pain Management and the Opioid Epidemic Symposium

Jill M Williams, MD
Professor Psychiatry
Director, Division Addiction Psychiatry
Robert Wood Johnson Medical School
• Addiction to opioids is a national crisis
• RWJMS supports White House initiative (May 2016) for medical schools to require prescriber education of Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, in order to graduate.
• Opportunity to review curriculum and enhance opportunities for continuity of content and identify potential gaps
Obama says tackling opioid abuse as important as combatting threat of terrorism

- President Barack Obama hugs Crystal Oertle after a panel discussion at the National Rx Drug Abuse and Heroin Summit
- Oertle spoke about her struggle with prescription drug addiction

Tuesday, March 29, 2016, in Atlanta

FACT SHEET: President Obama Proposes $1.1 Billion in New Funding to Address the Prescription Opioid Abuse and Heroin Use Epidemic

Crude rate per 100,000

Year

'70 '72 '74 '76 '78 '80 '82 '84 '86 '88 '90 '92 '94 '96 '98 '00 '02 '04 '06

Heroin

Prescription drugs

Crack cocaine
47,055 Drug OD in US 2014

More than ever recorded

28,000 opioid deaths

4X ↑ since 2000
Deaths opioid analgesics vs heroin


Oxycontin 30% all pain prescriptions.

Oxycontin + naloxone

Year:

- 2000
- 2002
- 2004
- 2006
- 2008
- 2010
- 2012
- 2013

Notes: The number of drug-poisoning deaths in 2013 was 43,982, the number of drug-poisoning deaths involving opioid analgesics was 16,235, and the number of drug-poisoning deaths involving heroin was 8,257. A small subset of 1,342 deaths was involved in both opioids and heroin.
Role of Prescribing

- % of patients
- % of overdoses

Likely involved in diversion
76% nonmedical users take meds prescribed for someone else
Rx Access Points—Friends & Family Source of Concern

Only 4% get them from a drug dealer

Medical School Curriculum

• Preferable curricula incorporate experiential and didactic components and inclusion of specialists

• Substance Use Disorder
  – Little – Few hours over 4 years (Report by NCASA, 2012)
  – Rarely clinical

• Chronic Pain
  – Mostly pain management
  – Acute pain physiology and management
CDC Guidelines: Use of Opioids for Chronic Pain - 12 Recommendations

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC’s Guideline for Prescribing Opioids for Chronic Pain is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for the patient and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

ASSESSING RISK AND ADDRESSING HARM OF OPIOID USE

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/opioid agonist-antagonist (ER/EA) opioids.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to a 50-mg morphine milligram equivalents (MME)/day, and should avoid increasing dosage to >50 MME/day or carefully justify a decision to initiate dosage to >90 MME/day.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. Benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies, and work with patients to taper opioid doses to lower dosages or to taper and discontinue opioids.

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9. Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for exercise. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11.Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapy) for patients with opioid use disorder.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html
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Curriculum Mapping

First Year
• Patient Centered Medicine: End of Life Care

Second Year
• Neuron Brain and Behavior: The Neurobiology of Pain
• Neuron Brain and Behavior: Opiates
• Neuron Brain and Behavior: Local Anesthetics
• Neuron Brain and Behavior: Addiction clinical and Neurobiology of addiction
• Clinical Foundations of Diagnostics and Therapeutics: The Placebo Effect

Third Year
• Surgery Clerkship: Acute Pain Management
• Medicine Clerkship: End of Life Care
• Medicine Clerkship: Musculoskeletal Pain
• Pediatrics Clerkship: Sickle Cell Disease
• Psychiatry Clerkship: Substance Use Disorders
• Patient Centered Medicine: Prescription Writing Workshop/ Controlled Substances
• Patient Centered Medicine: Prescription Opioid Abuse and Safe Prescribing

Fourth Year
• Emergency medicine clerkship-Toxicology
• Boot Camp

What is Missing?
Results

• Not included in MS 1 and 2
• Briefly: PMP, alternatives to opiates, risks/benefits in MS3
• Full Day in MS3: Chronic Pain Management Multidisciplinary Approach, JFK Rehab Institute
  Nearly all areas including CDC Recommendations explicitly
• Unclear MS4: Boot Camp
Opportunities

• Enhance continuity, curriculum thread
• Review with lecturers and see if opportunities to add even 1 CDC recommendation into identified lectures
• Increase emphasis in PCM- MS3
  – Multidisciplinary Session
• Identify opportunities for MS4
  – Boot Camp, others
• Residency?
• Supervising Faculty?
Patient Centered Medicine

- Third Year Medical Students Clinical Clerkships
- Integrated 3 hour Session on Chronic Pain and Opioid Misuse (Nov 16)
- Faculty from Chronic Pain, Family Medicine and Addiction Psychiatry

Objectives
- Increase Understanding of Interdisciplinary Treatment Approaches to Chronic Pain
- Increasing Understanding of Appropriate Use of Opioid Pain Medications vs Other Modalities for Pain Management
- Increasing Awareness about the Opioid Crisis and Contributing Factors
- Recognize the Signs of Opioid Use Disorder and Be Familiar with Protocols to Prevent Misuse Including Use of PMPs
Risk Factors for Opioid Use Disorder

• 10-20% of opioid users at risk (licit/ illicit)

• Higher Risk
  – Co-occurring psychiatric (depression/ ADHD)
  – Family history substance use
  – Prior substance use disorder
  – Men > women
  – Native Americans
  – Prescription pain user
  – Trauma exposure
Prescription Monitoring Program

- Statewide database on CDS (II- IV or V)
- To halt the abuse and diversion of prescription drugs
- Outpatient dispensing
- Access to prescribers and pharmacists (law enforcement, licensing board)
- Shared data between states
- Do not infringe on prescribing
- Mandatory enrollment
Appendix C – Kentucky Report Card Sample

CABINET FOR HEALTH AND FAMILY SERVICES
Commonwealth of Kentucky
275 East Main Street
Frankfort, KY 40621-0001
Drug Enforcement Branch KASPER
Peer Review Report Prescribing Comparisons

Below is a 90 day comparison of the number of year prescriptions and doses that were dispensed in Kentucky and reported to KASPER along with the average for all Kentucky prescribers and for the specialty area of primary care.

Prescription Counts

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<tr>
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<th>Benzodiazepines</th>
<th>Opioids</th>
<th>Sedatives</th>
<th>Stimulants</th>
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<tr>
<td>You</td>
<td>737</td>
<td>831</td>
<td>83</td>
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<td>Specialty Average</td>
<td>177</td>
<td>157</td>
<td>17</td>
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<tr>
<td>Kentucky Average</td>
<td>39</td>
<td>44</td>
<td>9</td>
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Count Comparison of Prescriptions Written

Dosage Counts

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<td>You</td>
<td>56721</td>
<td>7325</td>
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<tr>
<td>Specialty Average</td>
<td>12239</td>
<td>1582</td>
<td>442</td>
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<tr>
<td>Kentucky Average</td>
<td>2543</td>
<td>2772</td>
<td>817</td>
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Count Comparison of Doses Prescribed

Sample Report

Top 10 Drugs Prescribed By You in the Past 12 Months

- Methylenedinitrate (13%)
- Escitalopram (9%)
- Desvenlafaxine (11%)
- Clonazepam (8%)
- Aripiprazole (15%)
- Amphetamine & Comb. (17%)
- Phenytoin (6%)
- Zaleplon (4%)
- Sodium Oxybate (6%)
- Modafinil (13%)

Patients you have prescribed to in the past 12 months

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<th>Last Name</th>
<th>First Name</th>
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Telephone: (781) 609-7741 | Fax: (888) 705-8058 | Email: info@pdmpassist.org | Website: www.pdmpassist.org
Prescriber Report Card (KY, AZ, OH)

- Total # of prescriber’s patients receiving over 90 morphine mg equivalents (MMEs)
- Total # patients to whom the prescriber issued multiple controlled substance prescriptions (opiate and benzodiazepines)
- Total # patients getting opiates more than 30 days
- Total # patients receiving controlled substances prescriptions from 3 or more prescribers or pharmacies
- Total # patients with CDS dispensing date overlap or early refills

A letter is sent with the report emphasizing that the purpose is to promote appropriate prescribing for the selected drugs
Medication Assisted Treatment

• Evidence of poor treatment outcomes from detox alone
• Stigma of being on maintenance treatment
• Still need access

• Drug Addiction Treatment Act (2000)- Office Based Treatment for Opioid Use Disorder
• Medications and psychosocial treatment

• Buprenorphine (Suboxone)
• Methadone
• Naltrexone (Vivitrol)
Causes of Death in Opioid Using Population

N=68,066 hospitalized in CA for opioid 1990-2005

Veldhuizen et al., 2014
Conclusion

• More and enhanced curricula

• Medical student- Residency training and Continuing Education (in practice)

• Follow CDC Guidelines Regarding Use of Opioids for Chronic Pain

• Diagnose and Treat SUD

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