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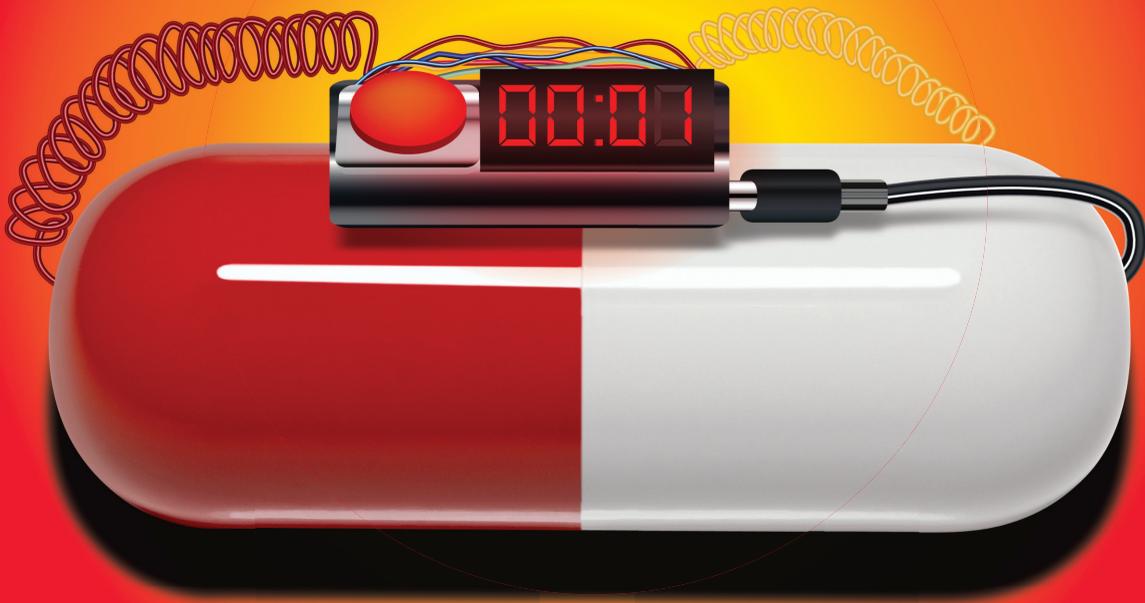
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# OPIOID CRISIS

How physicians can help patients, community



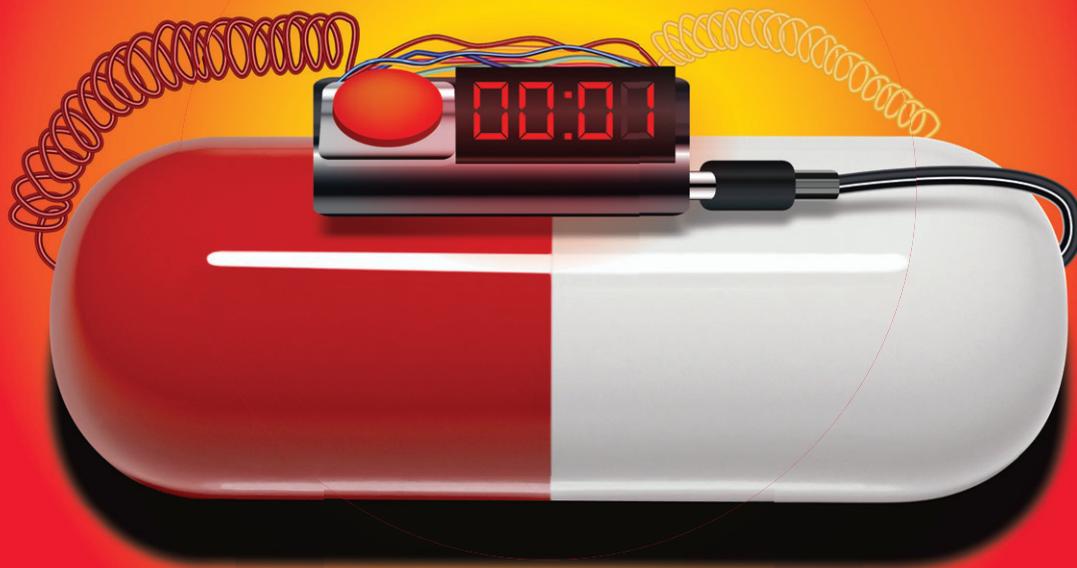
Law enforcement's  
view of the epidemic

A patient's path  
to recovery

One doctor's  
approach

# OPIOID CRISIS

## How physicians can help patients, community



by **JEFFREY BENDIX** *Senior editor*

After years of simmering in the background, opioid abuse has exploded into the worst public health calamity the nation has faced in decades. Tens of thousands of people die from overdoses each year, with many more becoming addicted or physically dependent on the medications. The crisis has seeped into virtually every part of the country and touched individuals and families from all types of backgrounds.

The severity of the problem, combined with news stories about high-profile deaths, such as

the son of the mayor of Nashville, Tennessee, sometimes creates the impression of opioid abuse as an unstoppable—and incurable—epidemic. But doctors who treat patients with opioid dependencies or addictions paint a different picture. Addiction is a chronic disease, they say, and like other chronic diseases it can be managed. But doing so requires time and money, along with a changed attitude among many lawmakers and members of the public.

**A patient's path  
to recovery**

**PAGE 34**

**Law enforcement's  
view of the epidemic**

**PAGE 35**

**One physician's  
approach**

**PAGE 36**

**IN AUGUST,** President Donald Trump formally accepted what public health experts, law enforcement and physicians have been saying for years: opioid abuse is a deadly epidemic, and should be declared a national emergency.

As with any major public health problem, the spread of opioid addiction has many causes, including a belated recognition of just how potent the drugs can be. “I think a lot of us, me included, underestimated the power opioids have over certain people,” says Greg Sullivan, MD, who has been conducting clinical trials of drugs designed to help people overcome opioid addictions for more than two decades while practicing as an internist in Birmingham, Alabama.

Especially at risk, he notes, are individuals “with ongoing stress in their lives or psychological issues that they feel are improved by taking these medications.”

In their earlier willingness to prescribe opioids, Sullivan adds, many physicians—himself included—were responding in part to The Joint Commission’s 2001 standards on pain assessment and treatment. Many thought the Commission had endorsed the use of pain as a patient vital sign—a perception that the commission has since refuted.

Moreover, he notes, some payers had begun including patient pain management in their physician evaluations, and studies had appeared in leading medical journals claiming that patients with chronic pain were not getting addicted to opioid medications. “It was a perfect storm that led to the overprescribing of opioids” for pain management, Sullivan says.

## WHAT DOCTORS CAN DO

So what can doctors do in their own practices to curb the availability of opioids, and to help those who have developed an addiction to the medications? And what systemic changes do they think could help achieve these goals?

Experts say a good place to start is by following the recommendations in the Centers for Disease Control and Prevention’s 2016 guideline regarding the use of opioids for treating acute pain, such as that following surgery or a bad accident: prescribe the mini-

## INSIDE THE CRISIS

**That opioids constitute a public health challenge of massive proportions is beyond dispute.**

In 2015, about **33,000** Americans—slightly more than 90 per day—died from opioid overdoses, according to the Centers for Disease Control and Prevention (CDC).

Of those, **15,000** involved prescription opioids. Overdose deaths involving opioids (both prescription opioids and heroin) quadrupled between 1999 and 2015, with per-person increasing from 180 to 640 morphine milligram equivalents over the same period.

The CDC estimates the annual cost of opioid abuse, overdose and dependence is

**\$78.5 billion.**

imum number and potency needed to get the patient past the worst of the pain, then look for alternatives such as non-steroidal anti-inflammatory drugs and/or physical therapy.

“Basically, the CDC is saying ‘when people come in with limited problems, don’t make them opiate addicts,’” Sullivan explains. The guideline was intended mainly for primary care physicians, who now write nearly half of all opioid prescriptions, and among whom prescribing rates have been increasing faster than other specialties, according to CDC data.

## PREVENTING DOCTOR SHOPPING

Helping patients who have used opioids for extended periods—due either to chronic pain or addiction, and weaning them off the medications—present far greater challenges, doctors say.

One of the biggest is guarding against doctor shopping—patients who seek opioid prescriptions from multiple providers. In recent years, states have acted to combat

## Minimizing the legal risks of opioid prescribing

The addictive and potentially deadly nature of opioids puts physicians who prescribe them at heightened risk for malpractice lawsuits. But thorough patient workups, combined with detailed documentation, can help prevent—or at least minimize the impact of—lawsuits tied to opioid prescribing, says Denise Hill, JD, MPH, an attorney and mediator with the law firm Whitfield & Eddy in Des Moines, Iowa.

According to Hill, civil lawsuits are the most common threat to physicians who prescribe opioids. Typical charges in such cases, she says, are for negligence in monitoring patients in their use of prescription opioids or failure to consult the state Prescription Drug Monitoring Program before writing a prescription. Doctors can also face sanctions from their state medical board, ranging from a letter of reprimand up to suspension or revocation of license.

Hill recommends a three-pronged approach for avoiding opioid-related lawsuits:

- **Using a “judicious approach” when prescribing the medications—screening to ensure the patient is a good candidate for opioids, limiting doses and quantities to the lowest needed to help the patient, and looking for alternative forms of treatment**
- **Thoroughly documenting all treatments and decision-making. “This is an area where you can’t afford not to have detailed records of why you did what you did,” she advises. “It’s important to take the time to put in extra impressions and facts about that patient. Document, document, document.”**
- **Obtaining continuous education regarding the effects of opioids, changes in laws and guidelines governing their use, and alternative forms of treatment.**

the practice by establishing Physician Drug Monitoring Programs—electronic databases for tracking the prescribing and dispensing of controlled prescription drugs. These programs enable doctors to learn what other prescriptions for controlled substances a patient has had filled in that state.

Careful screening of patients also helps to prevent doctor shopping. Susan Osborne, DO, a primary care provider in the rural town of Floyd, Virginia, has members of her staff question potential new patients as to why they want to see the doctor, and whether they’re calling on behalf of themselves or someone else.

“If it’s something like a mother calling on behalf of an adult child or wife calling for a husband, that can be a red flag,” Osborne notes. Another sign of possible doctor shop-

ping, she says, is a patient refusing to release his/her records from previous physicians.

## PAIN MANAGEMENT CONTRACTS

Patient pain management contracts are another tool doctors often use both to help patients and ensure they aren’t selling or giving away opioid medications. Such agreements generally require the patient to come in regularly for urine tests and pill counts.

Robert Raspa, MD, a primary care physician in Jacksonville, Florida, says his practice instituted them about a decade ago after a nearby medical center stopped accepting patients with Medicaid coverage.

“All of a sudden new patients started showing up saying they needed their medications renewed,” he recalls. “We knew it was a dangerous situation we weren’t prepared to handle, and one way we responded was to institute these contracts.”

Marla Kushner, DO, a primary care physician in Chicago, focuses solely on helping patients with opioid dependencies or addictions, and usually with the aid of medication-assisted therapies such as Suboxone (buprenorphine). Her contracts include the requirement that patients attend 12-step programs, such as Alcoholics or Narcotics Anonymous, as part of their treatment. It’s part of her larger conviction, which she emphasizes to patients, that success in managing addiction, or overcoming dependency, ultimately is up to them.

“I always tell them, ‘you don’t have a choice to have this disease, but once you know you do, you can decide what you’re going to do about it. Are you going to take your medication, are you going to work a program?’ That’s where the choice comes in,” she says.

## ADDICTION AS A CHRONIC DISEASE

Like many physicians, Kushner has had to drop patients who break the terms of their contracts, such as requesting refills by tele-

**Law enforcement  
and a patient speak out  
on the crisis**

Continued on page 33



*Continued from page 16*

# Physicians take on the opioid crisis

phone rather than coming to the office. But she doesn't drop patients if they relapse, due to her belief that addiction is a chronic disease, and needs to be managed like other chronic diseases such as diabetes.

"A diabetic eats a piece of chocolate cake. That doesn't mean we're going to kick them out of the practice," she points out. "We work with them to figure out what we could have done differently to keep their blood sugar under control."

The same approach should apply to people with opioid addictions, she says. "I want patients to feel if they relapse this is a safe place for them to talk about it so we can come up with a different plan," she explains.

Educating patients, both about the effects of opioids and the importance of not allowing other people to have access to them is also important. That's especially important for families with children, says Sandra Adamson Fryhofer, MD, an Atlanta, Georgia internist. "I've had some patients whose kids have gotten hooked on drugs from something they found in the family's medicine cabinet," she says.

Because of that, she tries to make clear to all her patients the importance of keeping medications out of the reach of children and teens. "I want them to be aware that other people may have access to what's in their medicine cabinet," she says.

Kushner stresses the importance of informing the public about the true nature of addiction but with a different emphasis. "I think it would be helpful to educate people more that opioid addiction is a disease, not just a weakness and not something people choose to go through," she says.

## THE IMPORTANCE OF THOROUGH WORKUPS

A further important element in battling opioid abuse, doctors say, is a thorough and detailed work-up of new patients seeking opioid prescriptions.

Sullivan, for example, says his patients generally fall into one of three categories—patients whose functions can be improved with pain medications, including opioids,

opiate-dependent patients who can't function without them and people seeking to divert (sell) their medications. For patients in the first two categories, he assesses their level of opioid tolerance and how the medications affect other parts of their lives.

"Any time I see patients taking opioids, but they are fully functional in their job and able to take care of themselves, then I feel comfortable prescribing these medications," he explains. "If I see decreased ability to function, that's a dangerous sign and I change them to less-sedating medications as soon as possible."

Kushner emphasizes family histories in her patient workups, looking for evidence of alcoholism or other forms of substance abuse. "That may show a genetic link [to dependency]," she explains. "And if it looks like my patient does have the potential for addiction, I'm going to be a little more conservative with them and do closer follow-ups."

## SYSTEMIC CHALLENGES

Despite their best intentions, however, doctors admit they are often hamstrung in their efforts to battle the spread of opioid abuse by the same factors that hinder other initiatives to improve patient health: lack of time and money.

The entire healthcare system, they say, is geared toward getting patients in and out as quickly as possible—exactly the opposite of what a patient struggling with addiction requires.

"A doc can say, 'I'll spend time talking to my patient explaining the danger of these drugs and trying to get them to go to physical therapy instead, or I can write a prescription and have them out in five minutes,'" Raspa says. "It sounds callous, but in a busy practice where you want to get back to treating patients with diabetes and heart failure, it's a quick way to get them out of your office. Doctors are being pressured from many sides, and sometimes they don't do the right thing."

Raspa adds that he'd address the problem by eliminating the pain scale, and anything

*Continued on page 35*

*Continued from page 33*

having to do with narcotics from patient satisfaction surveys. He'd also increase the number of rehabilitation centers. "It would be nice to get people off these meds in a safe, controlled environment," he says.

Osborne notes that many of her patients who use opioids have "complicated psychosocial histories. Many times they're in messy marriages and living nightmare lives," in addition to battling problems such as obesity and

smoking. Thus weaning them from the medications requires addressing the other issues in their lives, a process that requires a great deal of time and patience.

"I spend at least an hour with each patient, do house calls, attend school conferences, educate other providers," she says. "That helps patients to be well and safe, and causes me to be poor, because the [healthcare] system doesn't recognize that type of work. That's what gets so frustrating." ■

## The view from law enforcement

In his 14 years as a narcotics investigator, Sgt. Larry McLaughlin has seen a significant shift in patterns of drug use. When he started out, he recalls, most of his arrests were for selling or using crack cocaine. Now they are for opioids or heroin.

McLaughlin is part of a drug task force in Mahoning County, Ohio, which includes Youngstown and several other blue-collar communities. "Heroin and opioids have made a huge impact around here," he says. "It's really leading the charge as far as deaths, thefts, property crimes in this area," he says.

The county's death toll from drug overdoses has been steadily rising in recent years—from 61 in 2015 to 93 in 2016, and by mid-May was on track to surpass 100 for 2017. That's due in part, McLaughlin says, to the fact that some heroin now also comes laced with the powerful but deadly analgesics fentanyl and carfentanyl.

McLaughlin has advice for physicians who prescribe opioids. "Give your patients quality time and quality treatment," he says. "If there are alternatives, seek those. And follow up to make sure they're using [the medications] correctly, and if they're not, cut them off immediately.

"Doctors took an oath to preserve and defend people's lives, just like I did," he adds. "Don't just push them through your office, help to guide them through life."

OxyContin were the first opioids to appear in his jurisdiction, McLaughlin says, and when they did they spread rapidly. The fact that they cost as much as \$65 per pill, led to other problems. "I don't care what you do for a living, if you're taking four or five at a time multiple times a day, that's going to add up to quite a bit of money in a hurry," he notes.

When users can no longer obtain opioids from doctors or afford to buy them on the street, McLaughlin says, they turn to



Sgt. Larry McLaughlin

**"Doctors took an oath to preserve and defend people's lives, just like I did. Don't just push them through your office, help to guide them through life."**

heroin. It costs less and creates a similar feeling of euphoria—but only temporarily.

"After a while they get to a point where they're no longer getting high," he says. "They're not using it to party, it's so they can just get out of bed and function until the next day, when they have to do it all over again. They're just maintaining, trying to function enough to get through the day," he says.

"Not everyone using these drugs are rotten people," he adds. "Nobody wants to be stealing from their family, but these drugs get such control it has

them doing things they can't believe they're doing." McLaughlin estimates that up to 90% of property crimes and thefts in the area he covers are opioid-related. "People are doing what they have to to get their drugs," he says.

Although Mahoning County has been hit hard by job losses and

population decline, McLaughlin disputes the widely-held belief that opioid abuse is a symptom of poverty and despair. "All walks of life are affected by this," he says. "People in the city, the suburbs, different races, everyone. I've seen it hit people from great families and from broken homes. It doesn't make any difference."

McLaughlin advocates a three-pronged approach to curbing the opioid epidemic, starting with law enforcement—"targeting and arresting the people who are putting this poison on our streets," he says. In addition, he favors expanded treatment facilities for people seeking to break their addictions, and education, starting at a young age.

"I often speak at [elementary] schools and do the best I can, but what happens after that?" he says. "I think kids need to be exposed to the harsh realities of what these drugs do, and it needs to be constantly reinforced to let them know 'hey, this is bad.'" ■