Opioid Policy and Primary Care Practice

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Themes Covered

- Summary of health policy impact on medical practice
- Evidence-based research impacts legislation
- Significant research gaps
The health policy landscape:
There oughta’ be a bill
Legislation’s Affect on Our Practice

Some good:
• Improve patient care
• Streamline processes
• Expand resources for practice
• Increase clinical skills

Some bad:
• Increased administrative burden
• Harms patients and hurts access
• Adds risks and increases liability
• Rarely evidence-based

If legislators don’t hear from us, they assume we are in support!
Legislation dictating the practice of medicine versus professional discipline?

- Opioid prescribing limits by pill count, duration and age
- Mandated naloxone education and prescription offer
- CURES database breadth of use & required clinic protocols
- Mandated patient education topics in clinical practice
- Mandated electronic prescribing by 1/2021
Increased patient engagement versus administrative burden?

- Mandated diagnosis on prescriptions
- Mandated **education** topics in clinical practice
- Mandated **screening** for SUD & other risks
- **Serialization** of prescription paper
Increased clinical knowledge versus misguided oversight?

- Mandatory CME on risks for SUD, treatment and management
- Mandatory adoption of clinical prescribing protocol; medical record documentation when deviation
- Medical Board’s retroactive review of death records related to opioid overdose
In CA, the top 5% of clinicians wrote 30% of prescriptions and 49% of total MED.
What does the evidence say about initiatives implemented through policy?
<table>
<thead>
<tr>
<th>MEDICAL PRACTICE</th>
<th>LEVEL OF EVIDENCE FOR POLICY</th>
<th>CURRENT OR PROPOSED LAW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naloxone saves lives—strong evidence in limited circumstances</td>
<td>LIMITED</td>
<td>Mandatory prescribing and education at each prescription</td>
</tr>
<tr>
<td>PDMDs improve prescribing practices</td>
<td>OPINION</td>
<td>Frequency, varied drugs monitored, etc.</td>
</tr>
<tr>
<td>Serialized prescriptions deter forged prescribing</td>
<td>NONE/LOW IMPACT</td>
<td>Prescription pads with serial numbers</td>
</tr>
<tr>
<td>Evidence of increased mortality at higher MED</td>
<td>GOOD</td>
<td>Mandated limits on days supply, number of pills, age limits &amp; MED ceilings</td>
</tr>
<tr>
<td>Evidence of increased rates of SUD with chronic opioid use</td>
<td>GOOD</td>
<td>Mandated limits on days supply, number of pills, age limits &amp; MED ceilings</td>
</tr>
<tr>
<td>Deterrents for unsafe prescribing practices by prescribers</td>
<td>NONE</td>
<td>Case review of opioid deaths associated with unsafe prescribing practices</td>
</tr>
</tbody>
</table>
Research gaps to inform clinical care...and sound health policy
Key research questions...

- Best methods for deploying new clinical skills in medication management, MAT use, and tapering

- Understanding the consequences of SUD diagnosis on access to treatment, adequacy of pain treatment, stigma on controlled med use

- Optimal treatment programs for SUD including methamphetamines, opioids, and others

- Public health strategies to curb the rising use of heroin and methamphetamine

- Determine skills needed, how to train, and how to distribute health care workforce to optimally treat SUD
Avoid health policy defining medical practice.

Research informs better health policy.

Best health outcomes.