Combatting the Opioid Epidemic:
Promising strategies requiring national funding

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The American opioid epidemic is characterized by aggressive, antiquated prescribing practices, opioid diversion and misuse, and rising rates of overdose related death. The Centers for Disease Control and Prevention (CDC) estimate that 4.3 million Americans engage in non-medical opioid use each month (5) and 115 die each day from opioid related overdose (14). With mortality rates five times those in 1999, the opioid crisis has been named the deadliest drug epidemic in American history (14).

In response to the crisis, initiatives have been developed and implemented from the local community level to the federal government. Efforts encompass a variety of topics such as updated prescribing guidelines, state level laws and surveillance programs, health information exchange, targeted payer reporting, and community-based overdose education. Existing efforts have led to a national reduction in opioid prescriptions, but they have not produced a proportional reduction in overdose related deaths (15). Research highlights significant opportunity to improve primary prevention in the way of physician education, care management, surveillance and analytics, prescriber initiatives, judicial reform, payer policies, public health education, and primary and secondary prevention strategies.

Physician Education

As risks of prescription opioids have become clear, controlling their availability, and limiting patient exposure have become solution cornerstones. Opioid prescribing guidelines were published in 2016 by the Centers for Disease Control and Prevention to help clinicians avoid excessive or inappropriate prescribing, while ensuring access for qualified patients. Despite their widespread availability, resources must be devoted to increasing physician awareness and adherence. A 2017 study from a large academic health system revealed that only 67% of prescribers were aware of the CDC guidelines (1). One can assume that even fewer adhere to them.

Increasing awareness of opioid prescribing guidelines is a logical first step towards curtailing addiction, misuse, and overdose related death. Studies indicate that provision of continuing medical education (CME) can be an effective path for increasing guideline awareness and adherence in existing physicians. McCalmont et al. found that 72% of providers followed CDC guidelines after completing 11 or more CME credits (2). Given the magnitude of the epidemic and role of physicians, a minimum number of CME credits in opioid prescribing competencies should be required by states for physician license renewal.

The opioid prescribing knowledge gap will also need to be addressed in medical schools. Only 4% of American medical schools require students to complete a pain management course and only 16% offer such courses as electives (3). Throughout four years of medical school, as little as nine hours are devoted to pain education (4). Medical schools need to bring curriculum up-to-date and in line with opioid prescribing guidelines.
**Care Management**

Paramount for spreading guideline adherence will be the anticipation and mitigation of physician barriers. Existing time constraints in primary care, coupled with the additional time needed to fulfill CDC guidelines, is likely to pose the greatest challenge. This is supported by studies showing poor physician use of prescription drug monitoring programs (PDMP) due to time constraints (11). Care management and team-based care have effectively surmounted this type of barrier and can be applied here. Components of the CDC guidelines, such as educating patients on the risks of opioid therapy, reviewing history of controlled substances in the PDMP, screening for risk factors for opioid related harms, and coordinating urine drug testing can be delegated to a care manager. Implementing guidelines as a team will reduce time demands on the physician and increase the likelihood of guideline adherence.

As physicians prescribe opioids more conservatively and look to nonpharmacologic therapies to treat chronic pain, as the first CDC guideline stipulates, care management will again support adherence. The guideline states that cognitive behavior therapy, weight loss, and exercise are preferred therapies to opioids for the treatment of chronic pain (5). Appropriately trained care managers can deliver these interventions, which again will reduce time demands on the physician and support guideline adherence.

Primary prevention efforts should also focus on reducing demand for prescription opioids by recognizing populations most vulnerable to substance abuse and addressing drivers of vulnerability. A National Academy of Sciences report found that such drivers include eroded social capital in depressed communities, lack of economic opportunity, poor working conditions, and overarching hopelessness and despair (6). Widespread use of care management and better integration of behavioral health will be needed to chip away at these drivers. Though a handful of insurance plans reimburse for care management services, greater consistency in the market and expanded funding for behavioral health will be needed.

**Surveillance, Analytics, and Performance Monitoring**

Like care management, electronic medical records (EMRs) can support physicians in adhering to CDC prescribing guidelines. Clinical decision support in the EMR has been shown to improve adherence to clinical practice guidelines in the treatment of atrial fibrillation and could be used for similar purpose in the treatment of chronic pain (7). Additionally, on the spot pain management education could be provided to physicians by embedding educational links in screen prompts (4).

State run PDMPs represent both an area of success and opportunity in the fight against opioid abuse. PDMPs have been found to be so important in preventing opioid misuse that review of PDMP data prior to administration of an opioid prescription is one of the 12 CDC guidelines (5). Though successful in reducing opioid prescriptions, these systems are not without opportunity for improvement. Because these programs lack state to state interoperability, drug seeking patients can cross state lines and circumvent identification. In addition to interoperability, physicians often note that these systems lack intuitive design, making information retrieval time consuming (8). Despite their wealth of information, physician use of PDMPs can be poor in states lacking mandatory registration (4). States would be wise to improve PDMP interoperability, remove barriers to usage, and mandate physician registration.

The emergency department (ED) presents a special opportunity for health information exchange (HIE) to prevent opioid misuse. A 2017 study examining the contribution of EDs to opioid misuse and diversion found that 42% of opioids prescribed in the ED may ultimately be misused and 10% of all opioids diverted originate from an ED prescription (9). Although review of PDMP data can help identify patients prescribed controlled substances, data is not timely enough to identify patients who stop by multiple EDs in a single day. ED providers need real time data to manage high utilizing patients. The state of Washington implemented an internet-based HIE to share clinical information among ED providers. Implementation of this and seven ED best practices resulted in a 24% decline in controlled substance prescribing after ED visit among Medicaid beneficiaries over the course of one year (10). National adoption of ED HIE would help address systemic issues with opioid prescribing in EDs.
Performance monitoring will be crucial for further driving reductions in doctor shopping and inappropriate prescribing. The federal government could work with EMR vendors to create templates and reports that allow physicians to track and monitor prescribing. High level surveillance could also be conducted by extracting these reports from EMRs. To increase the value of these reports, data should also be extracted from HIEs and PDMPs and reconciled with EMR data. Sharing complete data and insights amongst providers will create additional accountability to reduce doctor shopping and improve prescribing practices. Funding should be made available to improve complete data capture, performance monitoring, and data sharing.

Prescriber Initiatives
States and insurers also play key roles in supporting prescriber adherence to CDC guidelines. Prescribing laws modeled after the CDC guidelines have been enacted in many states. Most focus on physician review of the PDMP and limiting daily supply and dosage of opioids. Insurers too have adjusted their policies to limit daily supply and dosage, require PDMP review, and pre-authorization for extended supply and long-acting opioids. In some cases, insurers only cover abuse deterrent formulations.

Insurer reporting offers opportunity to improve prescribing habits, address misuse, and prevent overdose. As part of their initiative to reduce opioid prescribing to pre-epidemic levels, Cigna generated three key provider reports. The first highlights individual physician prescribing habits and compares them to community peers and CDC guidelines. The second identifies patients who may potentially misuse or overuse opioids. Cigna engages with physicians on these patients to ensure prescriptions are safe, medically necessary, and clinically appropriate. Targeted areas receive the third report, which predicts patients likely to suffer from an overdose. This reporting suite, in addition to other strategies, led to Cigna’s 25% reduction in opioid use over the course of two years (13).

Blue Cross Blue Shield of Michigan (BCBSM) has provided monthly reporting around likely inappropriate opioid usage since 2013. Their ‘Doctor Shopper’ report is sent to prescribing providers of patients with opioid prescriptions from three or more providers, filled at three or more pharmacies, and with five or more opioid prescriptions dispensed. The ‘Triple Threat’ report lists patients with two prescriptions from each of three classes (opioids, benzodiazepines, and carisoprodol) within 90 days. This reporting was intended to reduce recreational usage given a lack of clinical indications for using all three simultaneously. In 2018, BCBSM began sending the patient numbers from these reports to the physician organizations managing their providers to expand reduction efforts. BCBSM combines this reporting with limits on supply and dosage, with the result of focusing on inappropriate prescribing and use rather than appropriate prescriptions.

Aetna also provides prescribers with a suite of reports to support prevention and intervention. Physicians receive reports that compare their prescribing patterns to peers. Prescribers with high volumes of extended supply prescriptions are identified as super prescribers and receive reports to that effect. Aetna also alerts providers to beneficiaries who may abuse or misuse opioids to support early intervention (18). Adoption of such reporting by other insurers would drive further reductions in opioid use.

Public Health
Outside the confines of the doctor-patient relationship, there is considerable need for public education around pain, the risk of opioids, and opioid use disorder. The National Pain Strategy developed by the Institute of Medicine provides an excellent framework for a public education program centered on prevention, becoming informed consumers, personal empowerment, setting realistic expectations, and self-care (4). A national public education initiative could leverage this framework and combat the conflicting messages consumers receive from advertisements, broadcast TV, and pharmaceutical marketing.

• Early Education
Middle and high school students should receive early education on the risks of opioid addiction. They would also benefit from an early introduction to safe prescription storage and disposal practices. Results from the 2013 National Survey on Drug Use found that half of survey respondents who reported nonmedical use of prescription opioids obtained them from friends or relatives with prescriptions (11). Drug take back programs can reduce unintended diversion and are widely available in many states but are poorly utilized for the disposal of opioids (12). Rather than discarding unused opioids, most patients keep them for future use (12). States could minimize opioid diversion by promoting and incentivizing disposal of unused opioids via drug take back programs. Addressing this at an early age will have an even bigger impact.

• Adult Education
In addition to early education topics, adults should receive education on opioid overdose and emergency administration of naloxone. A growing body of evidence supports community-based overdose education and naloxone distribution programs. These programs concentrate on individuals who use opioids along with bystanders at increased risk of witnessing an overdose. Content centers on how to respond to overdose and how to
administer naloxone, which is considered best practice for opioid overdose resuscitation. Research of such programs in communities with high rates of opioid overdose has found a significant reduction in overdose mortality.

Additional analysis points towards their cost effectiveness (11). Widespread implementation of such programs could significantly impact the rising rate of overdose related death in the United States.

Judicial System
The judicial system also represents an opportunity to reduce overdose related deaths by improving access to addiction treatment. A high volume of individuals in the criminal justice system are victims of opioid use disorder. In 2015, Vermont’s state police department found that 80% of the state’s inmates were either addicted to opioids or in prison because of their addiction (16). Many communities are implementing jail diversion programs that assess nonviolent offenders for addiction and connect them to treatment instead of incarceration. Not only are these programs breaking the cycle of addiction and incarceration, they are also proving to be cost-effective. California saved close to $100 million after the first year of implementing its jail diversion program (17).

For cases that warrant incarceration, improvements can certainly be made to addiction treatment provided to inmates. Access to treatment is staggeringly poor, with only 11% of inmates receiving any form of substance use disorder treatment. Failing to provide treatment is counterproductive given mounting evidence around post-release outcomes and cost savings. Relapse rates among criminal offender adults with a history of opioid dependence are lower after treatment with extended-release naltrexone than with traditional care. California saved nearly $18,000 per inmate when it treated opioid dependent inmates with methadone or buprenorphine instead of detoxification (17).

Payer Policies
To successfully combat the opioid epidemic, payers must provide comprehensive treatment for chronic pain. Failure to do so amidst the existing environment of restriction will drive patients to dangerous street drugs and increase opioid-related deaths. This is supported by statistics showing a national reduction in opioid prescriptions and a concurrent rise in opioid-related deaths involving synthetic opioids, particularly illicitly manufactured fentanyl (15, 14).

Significant restrictions on the daily supply and dosage of prescription opioids have been imposed by most payers. Even so, opioids are often easier to access than non-opioid pain therapies. Early analysis of a Department of Health and Human Services study suggests that U.S. insurance companies place fewer restrictions on opioids than on non-drug treatments and less addictive, non-opioid medications. For example, the nation’s largest health insurer, UnitedHealthcare, does not require prior authorization for morphine and places it on the lowest cost drug coverage tier. In contrast, it places Lyrica, a non-opioid, on it’s most expensive tier and requires patients to try multiple drugs first (18). To curtail the rising opioid-related death rate, payers cannot simply restrict opioid access. They must improve access to pain management therapies.

Conclusion
With sufficient focus and funding, research suggests that the American opioid epidemic can be brought under control. Physician education, care management, surveillance and analytics, prescriber initiatives, judicial reform, payer policies, and public health represent key areas for intervention.
Works Cited


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