Prescriber Education Initiatives
Impact and Effectiveness

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Presentation Agenda

• Background on opioid prescribing
• Literature review Methods
• Types of prescriber initiatives
• General evaluation findings
• Limitations of existing evaluations
• Role of PDMPs in evaluating prescriber initiatives
• General lessons learned
• Questions/Discussion
Acknowledgements

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Why focus on prescribers?

Source Where User Obtained Pain Relievers

- More than One Doctor (1.8%)
- Free from Friend/Relative (54.0%)
- One Doctor (19.7%)
- Other\(^1\) (5.1%)
- Bought on Internet (0.2%)
- Drug Dealer/Stranger (4.3%)
- Bought/Took from Friend/Relative (14.9%)

Source Where Friend/Relative Obtained

- One Doctor (82.2%)
- More than One Doctor (3.6%)
- Free from Friend/Relative (5.4%)
- Bought/Took from Friend/Relative (5.4%)
- Other\(^1\) (1.8%)
- Drug Dealer/Stranger (1.4%)
- Bought on Internet (0.2%)

Source: SAMHSA, 2012 NSDUH National Summary Findings Report
Background: Prescribing of Opioids

• Under-treatment of pain
• Promotion of opioid use for CNCP (e.g., OxyContin®)
• Federal, state, and private organizations role in influencing prescribing practices
• Guidelines for safe and effective opioid prescribing
Literature Review Methods

• Aim: conduct an inventory and review the evidence-base for initiatives aimed to influence prescribing behavior of CS, particularly for opioids.

• Systematic review of academic literature published between 2000 and March 14, 2013.

• Over 2,000 articles identified using PubMed database.

• Inclusion criteria: studies of initiatives aimed at prescribers.

• Exclusion criteria: evaluations of buprenorphine trainings.

• Final review consisted of 53 published articles on 49 initiatives.
Typology of Studied Prescriber Initiatives (aimed to influence opioids or other controlled substances prescribing)

- Comprehensive education or training
- Guidelines or recommended practices
- Monitoring (e.g., PDMPs)
- Legislative or regulatory mandates

Note: studied initiatives could fall into multiple categories.
Comprehensive Education/Trainings

• Continuing Medical Education (i.e., in-person)
• Web-based training
• Multi-model training
• Academic detailing
• Mandates (influences from legislation or state licensing agencies)
Education/Trainings: General Findings

- Increasing prescriber knowledge facilitates safer prescribing of controlled substances.
- Content typically included:
  - Issues related to chronic non-cancer pain and addiction
  - Pharmacology of opioids or other CS
  - Recommended best practices
  - Communication skills
Recommended Practices*: General Findings

• Studies reveal poor adherence and wide variation in the application of recommended practices.
  ➢ Did not result in consist use of practices designed to minimize drug-related aberrant behavior but found that patients at the greatest risk of such behaviors were more likely to be monitored (Krebs et al., 2011).

• However, when coupled with comprehensive training, greater adherence.

*Studies on the effect of releasing guidelines or recommended practices without training.
Monitoring of Prescribing Patterns
(using administrative data systems)

• Monitoring can have positive effect in influencing prescribing patterns/behaviors.

  ➢ Ease of use factor (i.e., PDMPs, hospital electronic ordering system)
  ➢ Changes made to existing administrative data system (i.e., PDMPs, Medicaid Evaluation & Decision Support)
  ➢ Use of unsolicited reports/alerts (i.e., PDMPs, Medicaid, REMS program)
  ➢ Awareness factor
Legislative or Regulatory Mandates: General Findings

• Limited studies suggest mandates have an impact.

- CA bill requiring CME on pain management (AB487)
- TN Board of Medical Examiners and Medical Foundation collaborative
- Denmark initiative to reduce certain CS
- CA PDMP system change
Common study limitations

• Sample size
• Study design
• Internal validity
• External validity
• Metrics used
Implementation Challenges

- Lack of familiarity and discomfort with guidelines/recommended practices (Victor et al., 2009)
- Work flow issues (e.g., some tools too burdensome) (Krebs et al., 2011)
- Inability to follow through on certain recommendations (e.g., specialist referrals, insurance not covering urine screens & sleep studies) (Albert et al., 2011; Cochella & Bateman, 2011; Morse et al., 2011)
- Varying or conflicting recommendations across guidelines & trainings (Lofwall et al., 2011)
- Based on expert consensus rather than empirical evidence (Morasco et al., 2011)
Other Challenges

• Limited technology access (i.e., internet) (Srivastava et al., 2012)

• Patient factor (Swiggart et al., 2012)

• Prescriber attitudes & beliefs (Clark 2011; Roth & Burgess, 2008; Spickard, et al., 1999; Sullivan et al., 2006)
DRUG-FREE AMERICA

AGE
0-4
AMOXICILLIN
4-12
RITALIN
12-18
APPETITE SUPPRESSANTS
18-24
NO-DOZ
24-38
PROZAC
38-65
ZANTAC
65
EVERYTHING ELSE
Potential Opportunities

• Incentives (financial vs. nonfinancial – ease of administrative burden)
• Booster sessions
• Mentorship/consultations
• Medical school or in residency training
• Accountability (peer reviews)
Beware of Unintended Consequences

“supply reduction ... in the absence of demand reduction and harm reduction could paradoxically increase overdoses.”

(Albert et al., 2011, p. S83)
Selected References


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