The Opioid Epidemic: Public Health Detailing to Primary Care Providers and Dentists

Prepared by Madison County Department of Health

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The Madison County Department of Health and BRiDGES Madison County Council on Alcoholism and Substance Abuse, Inc. embarked on a public health detailing campaign with primary care providers and dentists on behalf of the Madison County Opioid Task Force in the beginning of November 2016.

The Health Department compiled a list of all the primary care providers and dental offices in the county. The list included 11 family practice, 5 adult-only healthcare providers, and 17 dental offices for a total of 33 practices to visit. A detailing packet that included *The Opioid Epidemic: A Madison County, NY Perspective*, safe medicine disposal kiosk information, *Cautious Evidence-Based Opioid Prescribing* from the Physicians for Responsible Opioid Prescribing, and *Reducing the Risks of Relief—The CDC Opioid-Prescribing Guideline* from the New England Journal of Medicine was prepared for each practice. Chrystal Johnson, Public Health Educator II with the Health Department and Kim Nowakowski, Prevention Education Specialist with BRiDGES divided up the list, scheduled appointments, and concluded the visits in early December 2016. Visits ranged from 5 to 20 minutes with the majority lasting 10 minutes.

Of the 11 family practices in Madison County, eight practices were visited, one practice was consulted via telephone, and two were unable to be scheduled. Both practices that were unable to be scheduled received a detailing packet. One of these practices also has physicians on staff at the hospital's clinic in town, and two of the physicians were visited there. A total of 27 medical staff were visited in person and another doctor was spoken with on the telephone.

All of the five adult-only healthcare practices were visited, which included a total of eight medical staff.

Of the 17 dental practices, 16 were visited and one refused the visit and information. A total of 25 dental staff received the information and responded to our questions.

A grand total of 30 practices and 61 medical and dental office staff were part of this public health detailing campaign. We are pleased to share a summary of the feedback from the providers, which includes valuable information that will be used to help the Madison County Opioid Task Force to develop strategies based on the information and recommendations.

Thank you to all the providers who met with us.

Primary Care Provider Summary

Questions posed: What is your policy for prescribing an opioid-based medication? How many days are given? Do you counsel the patient on the addictive qualities of the medicine?

In general, providers described patients as falling into two categories: established patients and new patients. The adult-only healthcare providers were clear that they simply did not take on new patients with a history of opioid use. In the family practices, most patients on opioids are established patients, who have been inherited by a former provider of the practice. These providers find it is difficult to make the change to not using opioids with these patients.

Providers also described two types of patients: those with long-term opioid use and those not using opioids. Providers try to avoid prescribing for patients not already taking them, with one mentioning it is not indicated for orthopedic pain, such as back or neck pain. Across the board, providers are not prescribing long-term for patients not already on opioids, so as not to create a problem with new patients.

Providers find it easier to tell new patients "no." If they do prescribe new, then they tell the patient it is for a defined period. Most providers mentioned that they will prescribe as short of an amount of time as possible for acute pain. When asked what that length of time is, the typical response was one week at a time. One provider finds that by using the prescribing guidelines, he can say, "no, it's not within the guidelines" or "I'm not comfortable prescribing this."

One provider mentioned they prescribe to long-time patients with legitimate reason to be on opioids. Some prescribe a 30-day supply for chronic pain, and one mentioned they never prescribe over a 30-day supply. Several providers responded that it depends on the diagnosis. A few providers said they cannot use over the counter medication for [older] patients with complex health issues, such as diabetes or heart disease, and referenced damage to the kidneys with continued use.

One practice spoke of successfully weaning the patients, stating it takes time. When asked how much time, they responded that it can take six months. They mentioned weaning one patient who was medicated to the point of falling asleep during his appointments, and said the patient felt so much better after being weaned from opioids. A few other practices have had some success with weaning people down. It is hardest to not prescribe for patients who have been on opioids for a long time.

Primary Care Providers

Questions posed: How well do you think I-STOP is working to help identify patients who are seeking an opioid-based pain killer (such as hydrocodone or oxycotin) & who may be "doctor shopping"? Is it being used across the board and is it effective?

Providers who prescribe opioids indicated that they are using I-STOP consistently, and it works well. Some providers mentioned it is easy to use and is a good step to monitor if someone is getting prescriptions elsewhere. One provider mentioned that they tell the patients that their prescriptions are being tracked through the Prescription Monitoring System, so the patient can be held accountable. It gives the provider a tool to say, "No, I see you've already been prescribed." It is reassuring and provides more confidence to the provider when prescribing.

Some providers mentioned that it can be time-consuming and painful to use sometimes. One provider mentioned that it is only used in New York, so patients who are crossing state lines are unable to be identified. One provider mentioned that some people are savvy and realize that by a small change in their name such as a middle initial or hyphen means that they cannot be picked up in the registry. However, they said cross checking with addresses can help eliminate that. One FNP has found that pharmacists are not putting sleep aids in I-STOP. Several providers mentioned that the Emergency Room (ER) is a problem, stating that ER providers are prescribing opioids in addition to the primary care physician. Providers said that Emergency Room personnel need to know about I-STOP and use it consistently.

Questions posed: What do you do to help avoid unnecessarily prescribing opioid-based prescriptions to those who may need non-narcotic pain killers? Do you try to focus on over the counter items, such as ibuprofen or other NSAIDS for your patients?

Across the board, providers said they start with over the counter medication for pain. A few described talking to patients about topical therapies (NSAID gel), chiropractor, heat and ice, and massage. Many providers said they refer to pain management for chronic pain. One provider said he finds getting his patients into pain management difficult.

Some offices have a medical safety agreement in place with the patient that includes random urine drug screenings. One office said they could also do a pill count, but they do not do that as much as they could.

Some other providers mentioned the following:
"They don't ask (for opioids), and I don't offer."
"I need to pick and choose battles."
"I let the patient know the plan for cutting back."

Primary Care Providers

Questions posed: What is your policy for cases in which a person is seeking medication which you strongly believe is for non-medical needs? Do you counsel? Do you report internally?

Responses varied. Some said they simply say "no" to the patient, or if the patient is not due for a refill, they will not fill it. Some mentioned that they refuse, document pain with MRI, need a history before prescribing anything, counsel, and limit what they give them. Some offices described how they educate and counsel, explaining to patients that it is not for long-term use and discussing realistic expectations with the patient. Some offices do a contract with the patient for any controlled substance. They do a urine test in the beginning and wait for the results before they consider prescribing. They also do random urine screening if they think it is needed. One office said they have an alert in the chart for other providers to be aware of, and they work with behavioral health, which is right in the same office. They also refer to pain management.

A few offices said they no longer have a problem with this because they have earned the reputation as a provider who will not prescribe opioids. They mentioned they will likely see it again when a new provider comes in until that provider's reputation is established too.

Question posed: What do you think is the best way to help minimize and control the heroin and opioid-based addictions that exist?

- Screen patients and follow the opioid prescribing guidelines. Limit the quantities when they do go on it and have them come in frequently. Try them on therapies.
- Be up front that the providers will not prescribe and remain consistent across the practice.
- The word gets out about the providers who will not prescribe and opioid-seeking patients will not try to get prescriptions there.
- Don't start them on opioids and don't let addiction start in the first place. Spend the next two to five years to reverse it.
- Refer patients who are addicted to mental health for treatment program.

Primary Care Providers

Questions posed: Is there anything more we can do for you or provide to you? Is there anything else you wish to share?

Suggestions fell into the following categories:

Drug Disposal Kiosks

- Several providers pointed out that the permanent drug disposal kiosks are all located in the northern part of the county, and stated that they are also needed in the southern part of the county. Providers in Hamilton and Munnsville each requested a kiosk. While one provider suggested it be located in the police department, other providers stated that people are often intimidated by a police department and suggested it be placed in a pharmacy.

Access to Care/Treatment

- More resources are needed for people to turn to. There is a lack of resources to handle the problem in the County and in the region.
- Easier access to rehabilitation and pain management. (Pain management is out of county.)
- Patients need help getting into treatment. There are no long-term programs after the patient has gone into treatment the one time. They find patients are coming to them and admitting they have used street drugs and need help with their addiction. It is a slow process to wean off drugs; it can't be done all at once.
- How do the providers get the patients covered? Patients cannot afford it.
- Insurance will not cover topical creams. What else can they use for their pain that is covered and affordable? Insurance should allow help for getting off narcotics.

Patient Education

- Sponsor a class for chronic pain and education for how to manage arthritis.
- Information session to refer people to who say "nothing works." They're convinced opioids are the only thing that works for their pain.
- Addiction brochure for doctors' offices to hand out. The dangers of addiction potential.
- Use the media to educate patients.

Provider Education

- Providers need options for getting patients off opioids. What are other alternatives for pain?
- Providers are struggling with how to help people. They are lost about how, when, and what to do for chronic pain. People need a multi-disciplinary support system (counselors, support group). If they don't get painkillers from their provider, they may turn to heroin from the street. Patients who have been on it for 20 years are desperate. They are scared of hurting.
- Several providers stated that Emergency Departments are a problem and ER providers are in need of education. Orthopedics and oral surgeons were also mentioned as sources for prescribing.

Dentist Summary

Questions posed: What is your policy for prescribing an opioid-based medication? How many days are given? Do you counsel the patient on the addictive qualities of the medicine?

Of the dentists who prescribe opioids, most say they only prescribe three day's worth, which is in line with the guidelines. One described prescribing very rarely and sparingly; one prescribes one to two day's worth and the patient needs to be seen again before getting another one to two day's worth. Three dentists said they do not prescribe at all, stating that their patients do not need narcotics. One oral surgeon said that pain level is reduced by his use of laser, so his patients do not need narcotics. When prescribed for acute care, most patients have been referred to or have already scheduled an appointment with an oral surgeon.

Questions posed: How well do you think I-STOP is working to help identify patients who are seeking an opioid-based pain killer (such as hydrocodone or oxycotin) & who may be "doctor shopping"? Is it being used across the board and is it effective?

For many, I-STOP makes dentists think twice about prescribing because it is time-consuming. Some feel that it is too cumbersome, so they have stopped prescribing opioids. Some do not use it often, as they rarely prescribe opioids. One dentist stated that it does not appear to be used across the board, as she found a patient in the system who had been prescribed in several different places. Another mentioned they feel it is hit or miss. Another dentist mentioned that it helps him to identify patients who may be "doctor shopping". Other dentists mentioned they think I-STOP is great and they find it very informative, effective, and not hard to navigate.

Questions posed: What do you do to help avoid unnecessarily prescribing opioid-based prescriptions to those who may need non-narcotic pain killers? Do you try to focus on over the counter items, such as ibuprofen or other NSAIDS for your patients?

Most dentists say they rarely prescribe opioids. Instead, they tell patients to take Ibruprofen or other over the counter medication. It works just as well as narcotics, if not better, without the possibility of addiction. If someone has a toothache, they may need an antibiotic and over the counter pain reliever. Eighty-five percent of pain is infection-related and can be treated with an antibiotic. Some dentists referenced a study that shows that Tylenol® and Aleve® together work exceptionally well and are exceptionally safe. It works on inflammation and pain at the site, and there are no reactions. When patients take this combination before surgery, it stops the pain before it occurs. It is easier to stop the pain before it occurs then after it has already started. Another office said they get patients in in a timely fashion; it's so important to take care of the problem right away.

Dentists

Questions posed: What is your policy for cases in which a person is seeking medication which you strongly believe is for non-medical needs? Do you counsel? Do you report internally?

- It used to happen a lot, but is extremely rare now.
- He has not seen it in his two months in the practice, but says you can spot them a mile away. They come in saying, “only this works”. He educates them on what he’s going to do; his course of action and treatment.
- They let them know right up front that they do not prescribe narcotics. If prescribing, it is important to educate the patient on not driving while taking the medication and disclose to their employer in case of random drug testing.
- They use I-STOP to find out if abusing and refuse script if they do.
- One dentist said he hasn’t seen it.

Question posed: What do you think is the best way to help minimize and control the heroin and opioid-based addictions that exist?

- All providers to use I-STOP.
- Dentists should limit to a two to three day threshold when prescribing, then see the patient before prescribing again.
- Bring education and rehab.
- They have established a reputation for not giving it out. People know if a doctor is easy to get prescriptions from through word of mouth.
- Tell the patient about proper disposal. Can the pharmacy take them? Get a drug kiosk in Cazenovia, Hamilton, and Munnsville.
- For counseling and rehabilitation to teach that life is not painless or fair; that you need to develop coping skills to deal with pain rather than drugs.
- Careful review and resolve pain-causing agent, if possible. Manage patient pain with pain contract.
- Offer over the counter pain management, treat the problem, minimize the amount of opioids prescribed by doctors.

Dentists

Questions posed: Is there anything more we can do for you or provide to you? Is there anything else you wish to share?

- One dentist mentioned wondering what happened to the mandatory opioid training for providers? If training is mandatory, it needs to be convenient and provide [continuing education] credits.
- One office wanted to know where the drug disposal kiosks are located. They were referred to the cards in the detailing packet and subsequently asked for additional copies to distribute to patients.

Final Thought from a Physician...

"I'm glad you're doing this."

Primary Care Provider Practices

Detailing Visit—Family Practice

Bassett Oneida Health Center
Dr. Amanda Pierce
Grace Digman FNP
Nurse

Bassett Hamilton Health Center
Dr. Ellen Larson

Canastota-Lenox Health Center of OHC
Dr. Jeffrey Mulholland
Dr. Thomas Cummings
Ross Trent, PA

Chittenango Family Care of OHC
Nurse

Oneida Indian Nation Health Services
Dr. Seelan Newton
Christina Riggall, FNP

Family Health Center of CMH- Hamilton
Dr. Robert Delorme
Paula Welsh, FNP

Family Health Center of CMH —Morrisville
Dr. Sunny Nelson
Kate Dolan, FNP
Daria York, FNP

Family Health Center of CMH—Munnsville
Dr. Kerri Taylor
Nurse
Medical Assistant
Receptionist

Telephone-Family Practice

American Medwell

Dr. Ife Ojugbeli

Detailing Visit— Adult Only

Oneida Medical Associates
Dr. Marina Martyn
Kaitlyn Huysman, PA
Two nurses

Dr. Carmine Mastrolia

Dr. Richard Cohen

Dr. Purnachand Popuri

Xavier Medical
Dr. Diego Alvarez

Dentists

Detailing Visit

Bruce Stewart, DDS
7 additional staff

Samuel Barr, DDS

Charles Choi, DDS

James Colocotronis, DDS

Peter Demlein, DDS

Cazenovia Dental
Peter Fauth, DDS

Bassett Dental Clinic
Mildred Irizzary, DDS
Emily Johnson, DDS

Devan Berry, DDS

Oneida Dental Group
Administrative Assistant

Linda Boehm, DDS

Smile Solutions
Dorothy Kassab, DDS

Virinder Modgil, DDS

Chittenango Family Dental
Ahmed Badawy, DDS

Vikas Goel, DDS

Thomas Kozlowski, DDS

Hamilton Dental
Scot Ioset, DDS