

Policy Brief regarding the Mandating of Continuing Medical Education (CME) about Opioid Prescribing

October 8, 2016

This was written in regards to NJ State Senate Bill 2419. The bill “requires issues related to prescription opioids to be included in continuing education courses for certain health care professionals.” It requires the following hours for various medical professionals:

Midwives	1	Advanced Practice Nurses	6
Dentists	1	Physicians	1
Physician Assistants	1	Nurses	1
Pharmacists	1		

Two major suggestions:

- 1) Each medical professional should be required to attend a minimum of 3 hours per 2-year cycle**
- 2) These courses should neither be designed nor funded nor provided by the pharmaceutical industry. Allowing Big Pharma to be involved in these CME courses in any way could potentially poison the purpose of this bill¹. Legal written language should be put in place to ensure that does not happen.**

It is important to note that most individuals with an opioid problem started on prescription pills.

According to the American Society of Addiction Medicine² (ASAM):

- Drug overdose is the leading cause of accidental death in the US, with 47,055 lethal drug overdoses in 2014. Opioid addiction is driving this epidemic, with 18,893 overdose deaths related to prescription pain relievers, and 10,574 overdose deaths related to heroin in 2014.
- From 1999 to 2008, overdose death rates, sales and substance use disorder

¹ <http://greenagel.com/how-big-pharma-gets-doctors-to-push-its-drugs/>

² <http://www.asam.org/docs/default-source/advocacy/opioid-addiction-disease-facts-figures.pdf>

treatment admissions related to prescription pain relievers increased in parallel. The overdose death rate in 2008 was nearly four times the 1999 rate; sales of prescription pain relievers in 2010 were four times those in 1999; and the substance use disorder treatment admission rate in 2009 was six times the 1999 rate.

- In 2012, 259 million prescriptions were written for opioids, which is more than enough to give every American adult their own bottle of pills.
- Four in five new heroin users started out misusing prescription painkillers
- 94% of respondents in a 2014 survey of people in treatment for opioid addiction said they chose to use heroin because prescription opioids were “far more expensive and harder to obtain.

Dr. Nora Volkow, the head of the National Institute on Drug Abuse (NIDA), testified before a U.S. Senate Caucus on International Narcotics Control in 2014 and said this regarding the education of doctors:³

Education is a critical component of any effort to curb the abuse of prescription medications and must target every segment of society, including doctors. NIDA is advancing addiction awareness, prevention, and treatment in primary care practices, including the diagnosis of prescription drug abuse, having established four Centers of Excellence for Physician Information. Intended to serve as national models, these Centers target physicians-in-training, including medical students and resident physicians in primary care specialties (e.g., internal medicine, family practice, and pediatrics). NIDA has also developed, in partnership with the Office of National Drug Control Policy (ONDCP), two online continuing medical education courses on safe prescribing for pain and managing patients who abuse prescription opioids. To date, these courses have been completed over 80,000 times.

Dr. Vincent Beswick-Escanlar, a Preventative Medicine Resident at the Uniformed Services University in Bethesda, MD, succinctly summed up the case⁴ for mandating CMEs:

Continuing education for medical providers is one way we might be able to improve opioid prescription practices, and in turn, reduce misuse and overdose deaths. By

³ <https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2016/americas-addiction-to-opioids-heroin-prescription-drug-abuse>

⁴ <https://health.gov/news/blog/2016/06/could-state-laws-around-opioid-continuing-education-help-tackle-the-national-opioid-epidemic/>

*making sure that everyone who prescribes an opioid – doctors, dentists, nurse practitioners, physician assistants, and so on – **has the training to decide when opioid medications should and shouldn't be used, prescribers might be able to limit these drugs to only those patients who will therapeutically benefit from them, and avoid prescribing them when other pain management options might be more effective. It's not just about finding the right drug and dose – it's also about considering alternatives, dispensing just the right number of pills at a time, avoiding side effects, recognizing misuse, and so on.** Although continuing education is not a replacement for foundational education – like at medical or nursing school – it might help prescribers stay up-to-date with the latest guidelines and best practices, as well as the needs of their communities.*

I am certain that neither Dr. Volkow nor Dr. Beswick-Escanalar would agree that 3 hours that I have suggested are sufficient to address these issues, but we must set a minimum limit. You will hear (or read) testimony from doctors and professional groups that will argue against any bill that mandates CMEs about opioid prescribing, pain management or substance abuse. In 2014, the pharmaceutical and medical device industry paid out \$6.49 billion to doctors⁵. While some of that money was for research, some of it was also given out to encourage doctors to prescribe the drugs the pharmaceutical industry produces. A variety of recent studies have shown that doctors are more likely to prescribe a medication if they get a free lunch from the pharmaceutical company.⁶ Big Pharma not only gives money to individuals and businesses, but also to a number of professional organizations. **One can justifiably argue that that the pharmaceutical industry benefits from the ignorance of prescribing doctors.**

The American Medical Association (AMA) has opposed mandating CMEs for opiates. That organization has been behind on this epidemic since the beginning (at various times, the AMA has fought against PMPs, 7 day only first-time opiate prescriptions, mandated patient warnings regarding opiates, and requiring medical students take a course about substance abuse). The American Academy of Family Physicians (AAFP) also opposes mandating CMEs. Both organizations argue that mandatory training causes a burden for doctors.

⁵ <http://www.bloomberg.com/news/articles/2015-06-30/doctors-got-6-5-billion-in-14-from-drug-device-makers-in-u-s->

⁶ <http://well.blogs.nytimes.com/2016/06/20/drug-company-lunches-have-big-payoffs/>

The claim that it causes a burden is false:

a) Doctors have to take CMEs, and many states have 0 or only 1 mandated topic. NJ has 1 to 2 mandated courses (at most, NJ doctors are forced to take 8 hours of specific coursework every 2 years – the other 92 hours are up to them).

b) There is a free online HHS training at health.gov: “Pathways to Safer Opioid Use.”

Some doctors and their professional organizations complain that they fear litigation from patients who feel they have received inadequate treatment for their pain. They also cite that some insurance companies tie their reimbursement to patient satisfaction. In short, they are arguing that not prescribing opioids or suggesting alternatives will damage their practice.

c) It is difficult to understand how these are arguments against CMEs about prescribing opioids. In fact, they are compelling arguments for this exact type of course. Those aforementioned doctors may benefit from learning how to talk to their patients about pain and the different kinds of alternatives to medication.

Doctors and their professional organizations make claims that mandated CMEs are burdensome, that regulation can hurt their practice, and that government should not get involved in the regulation of medicine. **They are using these assertions to hide the real reason for their opposition: Big Pharma gives them money and legislation like this threatens Big Pharma’s profits.**

Big Pharma is also paying close attention to legislation such as this current bill. From 2006 to 2015, the pharmaceutical industry has “donated more than \$880 million nationwide on lobbying and campaign contributions.”⁷ Only 34% of US States require a course in either addiction, pain management, or opioid prescribing (NJ currently requires none of these). **Those donations are used to fight legislation like this from passing, or to ensure that legislation that does pass is weak (like a 1 hour course mandate on opioids).**

⁷ <http://bigstory.ap.org/article/86e948d183d14091a80f5c3bfb429c68/drugmakers-fought-state-opioid-limits-amid-crisis>

This bill is not burdensome. It is about consumer and patient protection, which is a key role in the purpose of government. NJ does not have burdensome CME requirements, and lags behind many other states in mandating training specific to this issue.

The number of CME hours per two year cycle varies from state to state. Arkansas requires only 20, while Washington State mandates 200. NJ makes doctor complete 100 CME hours every two years. Of those 100 hours, doctors have a great amount of leeway. NJ medical professionals are required to get 2 hours on end of life care each cycle. Those licensed prior to 2005 must also get 6 hours of cultural competence every two years. NJ does not currently mandate CMEs regarding chronic pain, opioid prescribing, controlled substances or substance abuse. As of October 1, 2016, 17 other states mandate CMEs in at least one of those areas.

States with mandatory CMEs regarding opiates: Maine, Maryland, Massachusetts, New York, North Carolina

States with mandatory CMEs regarding the treatment of chronic pain: California, Iowa, Nevada, Oregon, Rhode Island

States with mandatory CMEs regarding controlled substances and substance abuse: Florida, Kentucky, Mississippi, Oklahoma, South Carolina, Tennessee, Vermont

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