The Role of Buprenorphine and the Waivered PA

Training and Mentoring Project for Primary Care Practices Rural Oklahoma

Presented by: Timothy R. Braun, PA-C

With special appreciation for my mentor and friend, Robert Westcott, MD

RURAL OKLAHOMA MAT

Oklahoma Academy of Physician Assistants 44th Annual Fall CME Conference
September 20, 2017
Disclosure Information

Timothy Braun, PA-C

No Disclosures

Learning Objectives:

1. Discuss and understand the impact of Opioid Use Disorder (OUD).

2. Review tools and techniques for the detection and diagnosis of OUD.

3. Describe the role and practices utilized as a waivered PA in integrating the prescription and management of patients being treated with buprenorphine.

4. Introduce the Agency for Healthcare Research and Quality (AHRQ) project to help expand access to the Oklahoma Medication Assistance Treatment

Discuss and understand the impact of Opioid Use Disorder (OUD)

Discuss and understand the impact of Opioid Use Disorder (OUD)

Deaths have quadrupled since 1999[1,2]

183,000 people have died since 1999[1,2]

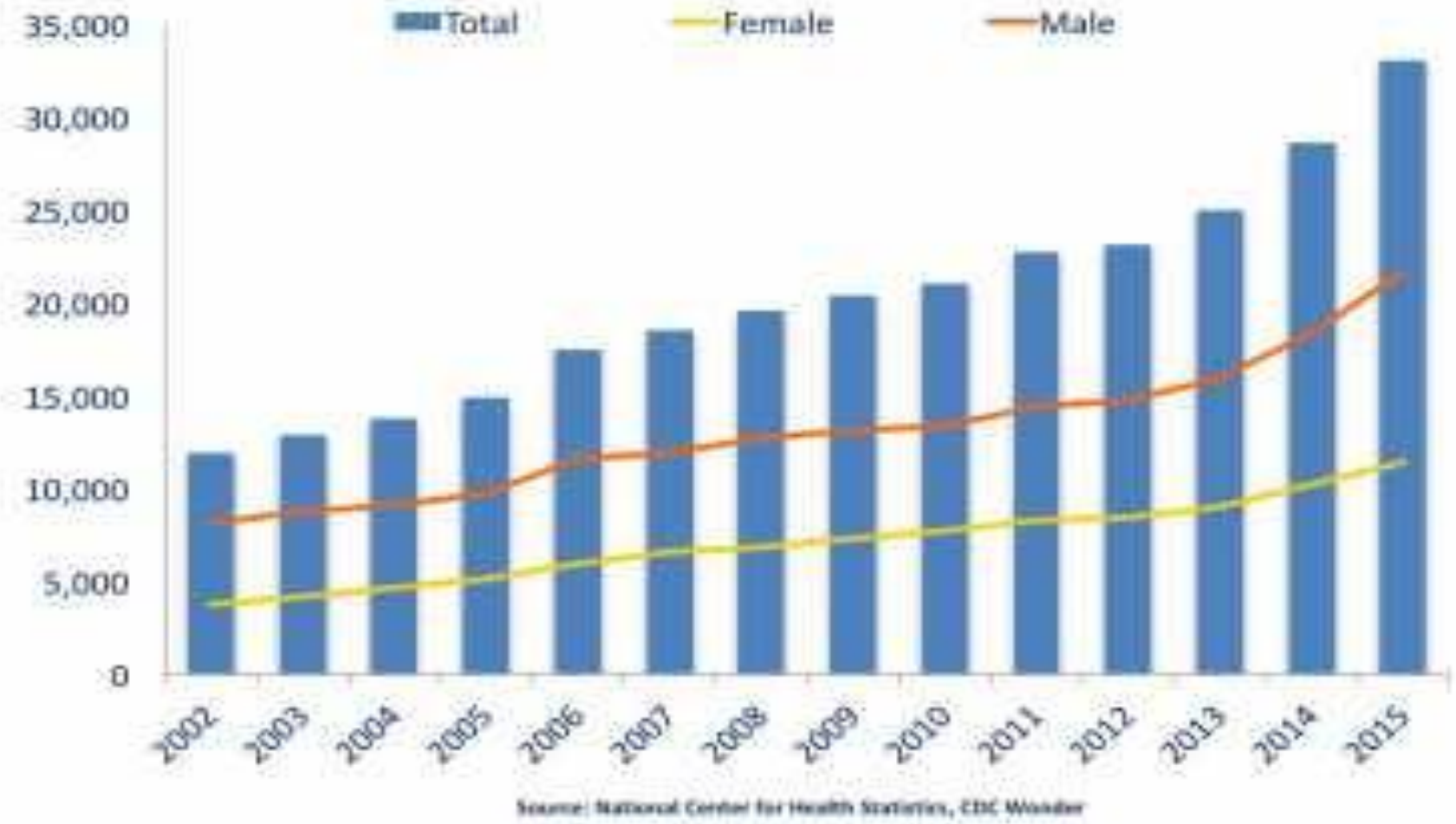
National Emergency

33,091 people died in 2015[1,2]

~2.6M people dx with OUD in 2014[1,2]

National Overdose Deaths

Number of Deaths from Opioid Drugs



Source: National Center for Health Statistics, CDC Wonder

Discuss and understand the impact of Opioid Use Disorder (OUD)

Addiction

- Inability to consistently abstain
- Impairment in behavioral control
- Craving
- Diminished recognition of significant problems with one's behaviors and interpersonal relationships
- Dysfunctional emotional response

6.1 million Americans abuse or misuse prescription drugs

Highest risk involve Opiates & Benzo combination

Discuss and understand the impact of Opioid Use Disorder (OUD)

Opioids

- **hydrocodone** (Lortab, Lorcet, Vicodin, Vicoproten, Hycodan, Zydon, Norco)
- **oxycodone** (OxyContin, Percodan, Percocet, Tylox,OxyIR, OxyFast)
- **methadone** (Dolophine)
- **morphine** (Kadian, Avinza, MS Contin, Depodur)
- **heroin**
- **tramadol** (Ultram, Ultracet)*
- **codeine** (Tylenol #3, Tylenol #4, Tussniex)
- **hydromorphone** (Dilaudid)
- **fentanyl** (Durgesic, Actiq, Sublinaze)
- **oxymorphone** (Opana)
- **meperidine** (Demerol)
- **buprenorphine** (Buprenex, Subutex, Suboxone)

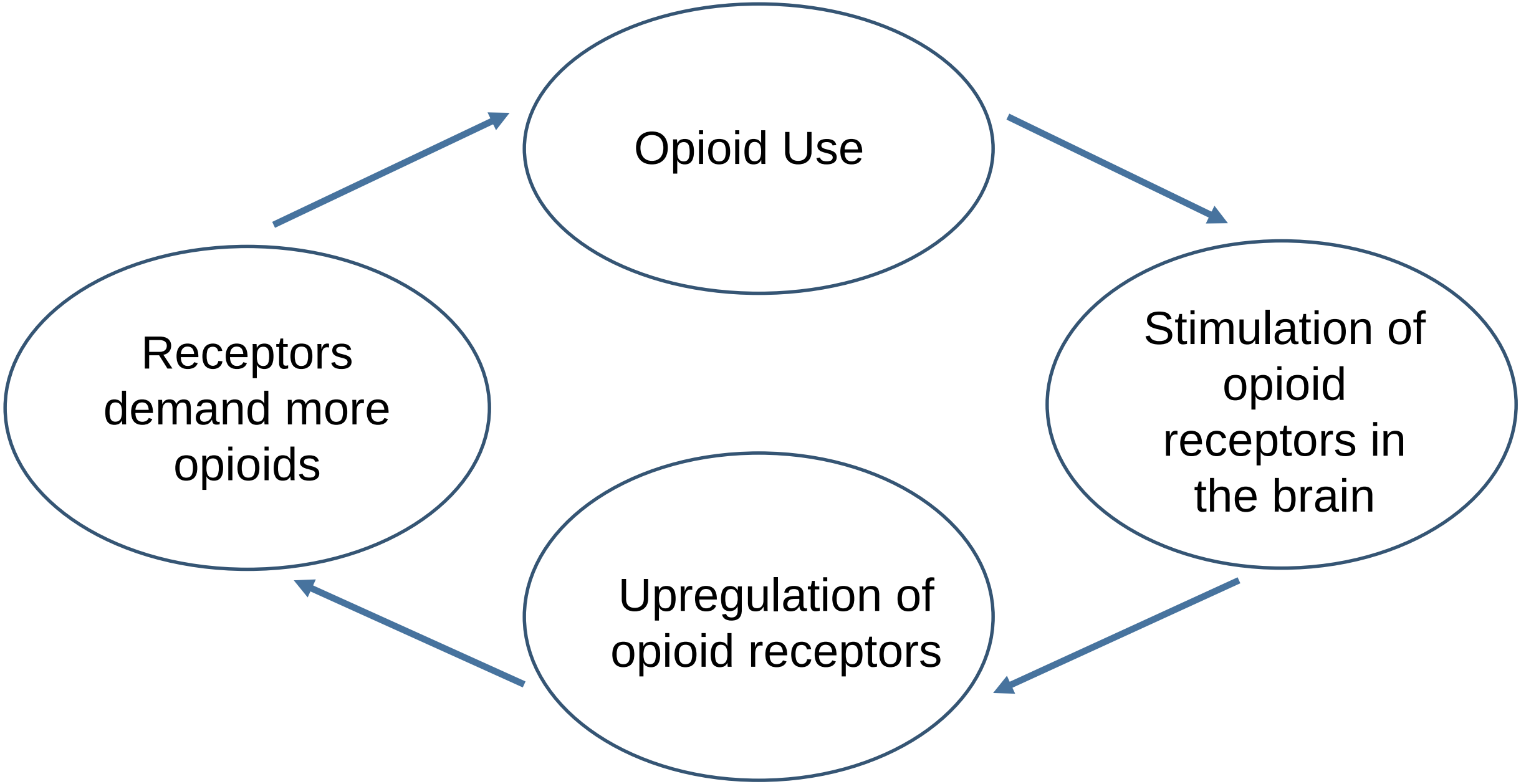
* Not a controlled substance by the DEA

Discuss and understand the impact of Opioid Use Disorder (OUD)

What can we do?

Prescription Monitoring Program

- Identify Doctor Shoppers
- Identify “Pill Mills”
- Allows Cooperation of Physicians, Pharmacist & Law Enforcement
- Studies have documented the effectiveness of PMP’s in reducing prescribing in ER’s & private practice.


Opioid Use
Stimulation of opioid receptors in the brain
Upregulation of opioid receptors
Receptors demand more opioids

Review tools and techniques for the detection and diagnosis of OUD

Review tools and techniques for the detection and diagnosis of OUD

- The NIH* and SAMHSA** recommend that physicians screen all patients over the age of 12 for potential substance abuse problems.
- CAGE-AID for initial screening

  In the past three months have you:

  1. Tried to cut down alcohol/drug use
  2. Felt annoyed by someone telling you to decrease alcohol/drug use
  3. Felt guilty about alcohol/drug use
  4. Used an “eye opener”

*National Institute of Health; ** Substance Abuse and Mental Health Services Administration

Review tools and techniques for the detection and diagnosis of OUD

Opioid Use Disorder Criteria (DSM 5):

A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe.

1. Taking the opioid in larger amounts than anticipated
2. Wanting to cut down or quit
3. Spending a lot of time obtaining the opioid

Review tools and techniques for the detection and diagnosis of OUD

Opioid Use Disorder Criteria continued:

4. Craving or a strong desire to use opioids
5. Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use

Review tools and techniques for the detection and diagnosis of OUD

Opioid Use Disorder Criteria continued:

7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use of opioids in physically hazardous situations
9. Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids

Review tools and techniques for the detection and diagnosis of OUD

Opioid Use Disorder Criteria continued:

10. *Tolerance (Does not apply for diminished effect when used appropriately under medical supervision)
11. *Withdrawal symptoms (Does not apply when used appropriately under medical supervision)

*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Review tools and techniques for the detection and diagnosis of OUD

- **Physical dependence**

  Adaptation to a drug that produces symptoms of withdrawal when the drug is stopped.

- **Tolerance**

  Reduced response to a drug with repeated use.

Review tools and techniques for the detection and diagnosis of OUD

- **Drug misuse**

  Obtaining drugs without a prescription or not taking medication as prescribed.

- **Overdose**

  Injury to the body that happens when a drug is taken in excessive amounts. An overdose can be fatal or nonfatal.

Review tools and techniques for the detection and diagnosis of OUD

Medication-assisted treatment (MAT)

Treatment for opioid use disorder combining the use of medications (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.

Integrating the prescription and management of patients being treated with Buprenorphine

Integrating the prescription and management of patients being treated with Buprenorphine

Integrating the prescription and management of patients being treated with Buprenorphine

Recovery

- Abstinence + a state of mind, that has embraced a lifestyle based on honesty and spirituality
- Cravings
- Relapses

Integrating the prescription and management of patients being treated with Buprenorphine

- Recovery is a complex process. Medication assisted therapy (MAT) is only one aspect of recovery.
- Support groups (NA, AA, Church)
- Treat the whole person- anxiety, insomnia, etc.

Integrating the prescription and management of patients being treated with Buprenorphine

Pharmacology:

Buprenorphine

- Partial agonist at mu* and delta opioid receptors, antagonist at kappa receptors
- High affinity

Narcan (naloxone)

- Competitive opioid antagonist

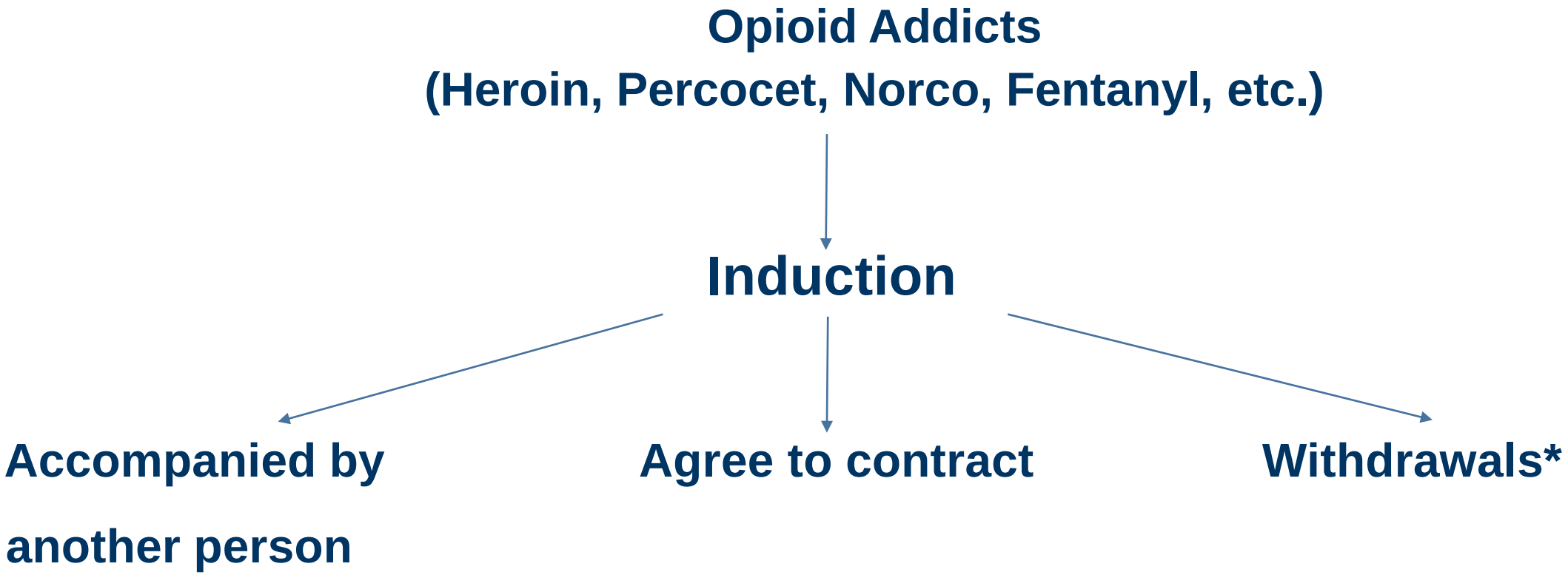
*mu receptors generate euphoric effect associated with opioid intoxication

Integrating the prescription and management of patients being treated with Buprenorphine

New patient wanting to initiate buprenorphine therapy in your clinic

- Opioid Addict vs Chronic Pain Patient
- Patient that has never taken buprenorphine
- Patient that has previously taken buprenorphine

Integrating the prescription and management of patients being treated with Buprenorphine



* Taken last opioid at least 16 hours before induction. Patient will experience anxiety, stomach pains, diarrhea, rhinorrhea, dilated pupils and general malaise

Integrating the prescription and management of patients being treated with Buprenorphine

Induction

- After the patient agrees to the terms of the contract, the induction can begin
- Order 1 tablet of buprenorphine (buprenorphine/naloxone) 8 mg /2 mg
- Spouse, family, friend can go pick up tablet

Integrating the prescription and management of patients being treated with Buprenorphine

Induction

- Break the tablet into 1/4th and advise the patient on the proper method to take the medication.
- Medication has to be placed under the tongue* and allowed to dissolve without swallowing.
- After the medication dissolves, the patient should wait 10 minutes before swallowing.
- Administer the first dose (1/4 of the tablet).

*Buprenorphine is absorbed in the buccal mucosa. Any medication that is swallowed will undergo first pass metabolism and not bind to opioid receptors in the brain.

Integrating the prescription and management of patients being treated with Buprenorphine

Induction

- Assess improvement of withdrawal symptoms after 30 minutes. The patient should start feeling a little better.
- Administer the 2nd dose.

Integrating the prescription and management of patients being treated with Buprenorphine

Induction

- Assess improvement of withdrawal symptoms after 30 minutes. The patient should start feeling much better.
- Administer the 3rd dose.

Integrating the prescription and management of patients being treated with Buprenorphine

Induction

- Assess improvement of withdrawal symptoms after 30 minutes. Withdrawal symptoms should be subsiding.
- Administer the 4th (and final) dose.

Integrating the prescription and management of patients being treated with Buprenorphine

Initial Management:

- Start patient with 4 mg/1 mg- 24 mg/6mg per day of buprenorphine
- RTC in 2 weeks to discuss dose adjustment
    - Are they taking the medication correctly- usually not
    - Are they going to meetings?

Integrating the prescription and management of patients being treated with Buprenorphine

Initial Management:

- RTC in another 2 weeks (3 visits the first month)
  - Discuss dose adjustments
  - Are they going to meetings?
  - RTC in 2 months

Integrating the prescription and management of patients being treated with Buprenorphine

New patient already on buprenorphine solely

- No induction needed
- Thorough H&P and decide on appropriate dose/assess recovery
- Are they taking the medication correctly?
- Going to meetings?
- We do not prescribe buprenorphine solely

References

1. CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016.

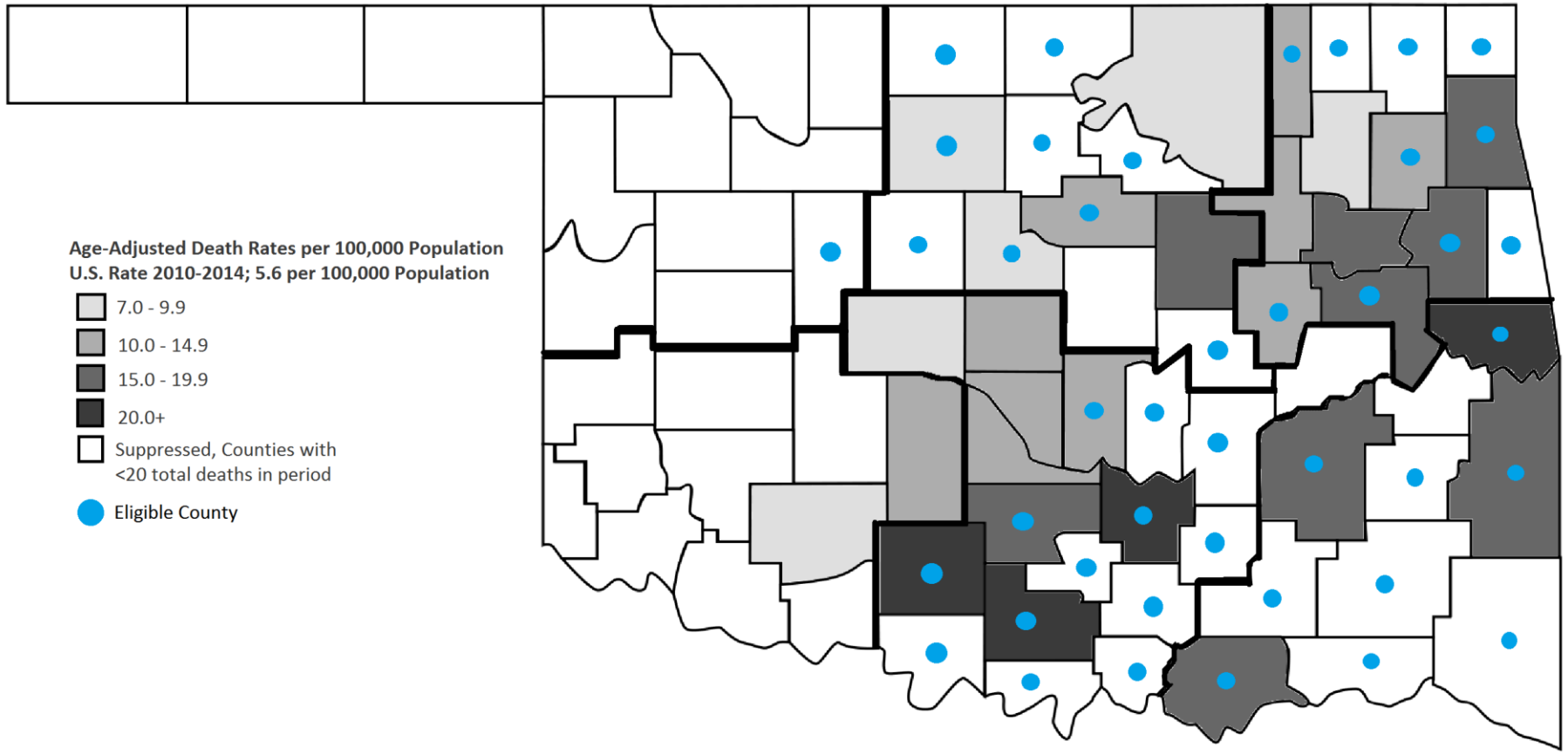
2. Rudd RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths- United States, 2010-2015. MMWR Morb Mortal Wkly Rep. ePub: 16 December 2016.

Introduce the Oklahoma MAT Project funded by the Agency for Healthcare Research and Quality (AHRQ)

Partners

- Agency for Healthcare Research and Quality (funder)
- American Institutes for Research
- Oklahoma Department of Mental Health and Substance Abuse Services
- American Society of Addiction Medicine
- ECHO Institute at the University of New Mexico Health Sciences Center

Despite multiple programs and dedicated health providers, the rate of opioid-related mortality in many Oklahoma counties is double that of U.S.



Age-adjusted drug poisoning death rate involving prescription opioid, by county of residence, 2010 - 2014

Medication-Assisted Treatment Expansion Program

Medication-Assisted Treatment for OUD

Combines medications with psychosocial services, to provide a whole-patient approach to the treatment of opioid use disorder (OUD).

	Medications in MAT		
	Methadone	**Buprenorphine (all formulations)**	**Naltrexone (oral and injectable formulas)**
Description	Full Opioid Agonist; Schedule II Drug; High Levels of Physiological Dependence **Not for office-based tx**	Partial Opioid Agonist; Mixed Opioid Agonist-Antagonist; Usually Provided in a Formula that Includes Naloxone; Schedule III Drug **Office-based tx with waiver**	Opioid Antagonist; Most Effective in Patients who are Highly Motivated or Legally Mandated to Receive tx; Non-scheduled Drug **Not a controlled substance**

*This information, as well as expanded definitions and additional material, can be found in ASAM's National Practice Guideline http://www.asam.org/quality-practice/guidelines-and-consensus-documents/npg/complete-guideline

Program Goals

- **Build on and with existing efforts** in Oklahoma to address the opioid epidemic
- **Expand access** to medication-assisted treatment for people living in rural counties
- **Reduce mortality rates** and improve the quality of life of rural Oklahomans
- **Support providers** to screen, treat, and care for people who are opioid dependent, while promoting whole-person sustained recovery

.

Regions Participating in the Program

- **Wave 1: Northeast and Southeast Regions**
  - Adair, Atoka, Bryan, Cherokee, Choctaw, Craig, Delaware, Latimer, LeFlore, Logan, Mayes, McCurtain, Muskogee, Nowata, Okmulgee, Ottawa, Pittsburg, Pushmataha, Sequoyah or Washington

- **Wave 2: North Central and South Central Regions***
  - Blaine, Carter, Coal, Garfield, Garvin, Grant, Hughes, Jefferson, Johnston, Kay, Kingfisher, Logan, Love, Marshall, Murray, Noble, Okfuskee, Pawnee, Payne, Pontotoc, Pottawatomie, Seminole, or Stephens.

**Recruitment for rural physicians, nurse practitioners, and physician assistants in north central and south central Oklahoma is occurring from 5/1/2017 through 10/1/2017.*

Program Resources Offered to Support MAT

1) Training opportunities

- Trainings in addiction medicine

2) Case-based learning via remote consultative clinics

- ECHO-model clinics with peers and addiction specialists

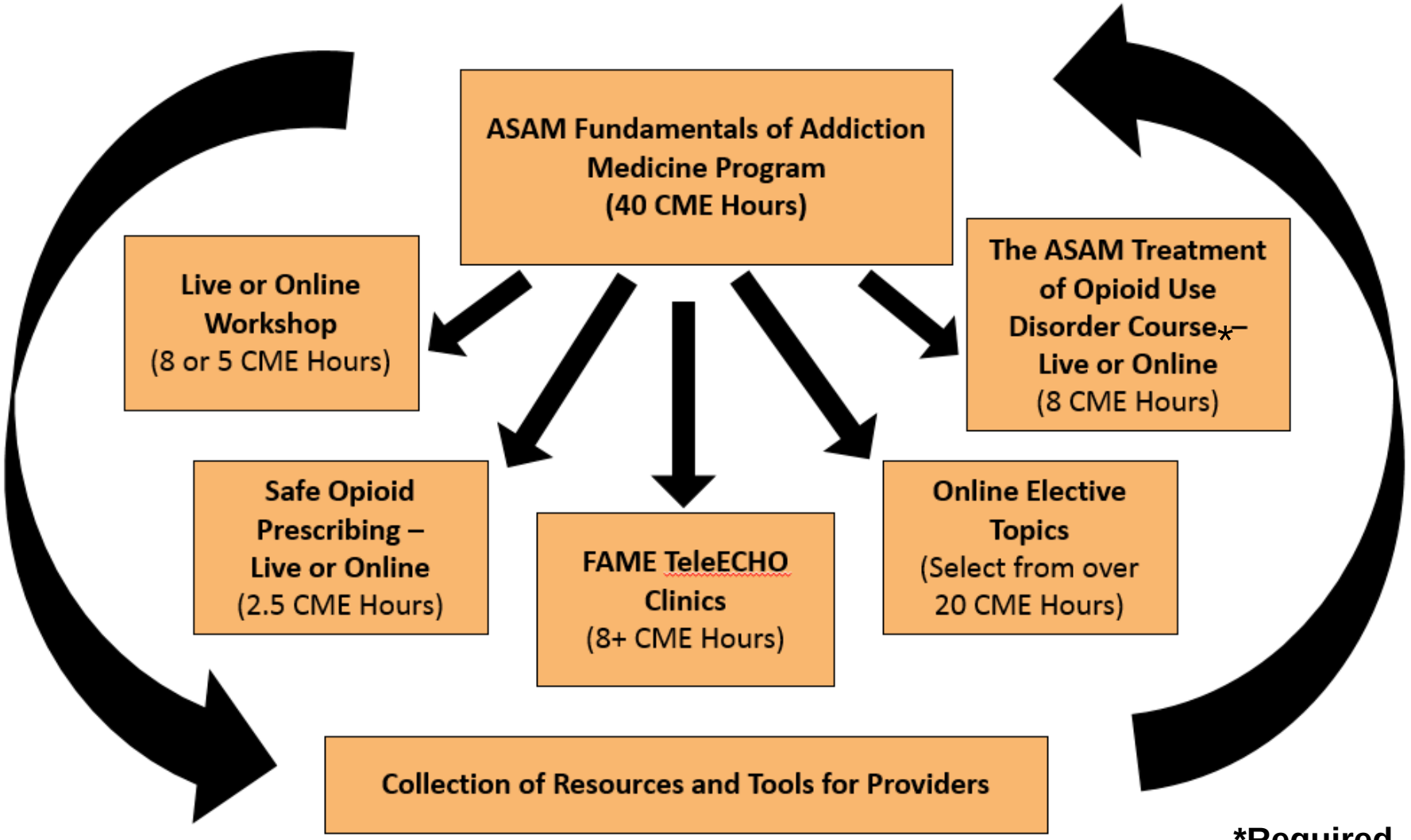
3) Mentoring by physician colleagues

- Access to colleagues who have successfully implemented MAT services

4) MAT-related supports for coordinating care

- Support for coordinating care with behavioral health and other indicated community-based services (“MAT Coordinator”)

Training & Education Opportunities



***Required**

ASAM American Society of Addiction Medicine

Timeline and Anticipated Time Commitments

Timeline and Commitment for North Central and South Central Oklahoma

DATE	ACTIVITY
January 2018	**½ Day Pre-intervention Training**
February 2018– September 2019	**Program Implementation**
• February – April 2018	• Attend the “Fundamentals” workshop and/or waiver course
• March – April 2018	• Receive waiver for office-based opioid prescribing for OUD
• April 2018	• Begin screening and treating patients
• February – November 2018	• Complete provider trainings and FAME clinics
• November 2018 – September 2019	• Program continues: additional ECHO clinics and online training options; continued access to physician consultants

Example Time Commitments for Training, Evaluation*, and Other Program Activities

	Participating Physician	Participating NP or PA	Practice Liaison/other staff
Required Training Only	20 hours (12 training+4 evaluation*+4 other)	36 hours (28 training+4 evaluation*+4 other)	31 hours (4 training+18 evaluation*+9 other)
Required + Strongly Recommended Foundational Trainings	32 hours (24 training+4 evaluation*+4 other)	48 hours (40 training+4 evaluation*+4 other)	31 hours (4 training+18 evaluation*+9 other)
Entire ASAM Fundamentals of Addiction Medicine 40-hour program *	52 hours (44 training+4 evaluation*+4 other)	52 hours (44 training+4 evaluation*+4 other)	31 hours (4 training+18 evaluation*+9 other)

* Evaluation hours assume the provider is not participating in the qualitative data collection component.
** Participants choosing to complete the full 40-hour program will have 10 months in which to complete its requirements

Consider Joining the Program!

For More Information: https://Oklahomamat.org

Or stop by our booth in the exhibit hall!

To sign up to see if you qualify to participate visit:
https://www.surveymonkey.com/r/OklahomaMAT

*This project is being funded through the Agency for Healthcare Research and Quality (AHRQ)

Questions?

Thank you!