



NC Department of Health and Human Services

NC Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC)

Coordinating Workgroup

May 10, 2018

Welcome! and Introductions of Attendees

- Welcome!
  - DeDe Severino

- Introductions of Attendees
  - Your name
  - Your organization/affiliation

Update: ED Peer Support Grant/Action Plan RFA

Jai Kumar & Elyse Powell

Federal and NC Regulations Governing OBOTs

Anna Stein

Brief History of MAT in the United States

- Harrison Narcotic Act of 1914 was interpreted as criminalizing the treatment of addiction with medication
- Narcotic Addict Treatment Act of 1974 allowed methadone to be used in registered Opioid Treatment Programs (OTPs)
- Drug Addiction Treatment Act of 2000 (DATA 2000) allowed qualifying physicians to receive a waiver of the requirement to register as an OTP to treat addiction with medication; allowed office-based opioid treatment (OBOT) with buprenorphine
- Comprehensive Addiction and Recovery Act (CARA) of 2016 allowed NPs and PAs to conduct OBOT treatment

Settings for Outpatient Medication Assisted Treatment (MAT)

Opioid Treatment Program (OTP)

Office-Based Opioid Treatment (OBOT)

What must a physician applicant certify to SAMHSA in order to receive OBOT waiver?

- Either has specialty certification in addiction OR has received 8 hours of training
- Has capacity to provide directly or by referral "appropriate counseling and other appropriate ancillary services"
- Will treat maximum OBOT patient load of 30
  - Can increase to 100 after a year
  - Can increase to 275 after additional year if meet several additional requirements

What must a physician applicant certify to SAMHSA in order to receive OBOT waiver?

- After SAMHSA determines that a practitioner meets the requirements for a waiver, the DEA gives the practitioner a DEA “X” number
- The DEA “X” number must be used on all prescriptions for buprenorphine treatment for opioid use disorder

NC: Registration with DHHS Drug Control Unit

- NCGS 90-101(a1) requires OBOT practitioners to annually register with DHHS
  - Shall document plans to ensure that patients are directly engaged or referred to a qualified provider to receive counseling and case management, as appropriate
  - Shall acknowledge the application of federal confidentiality regulations to patient information

OBOT Inspections

Overview of Current OBOT Capacity, Regulations

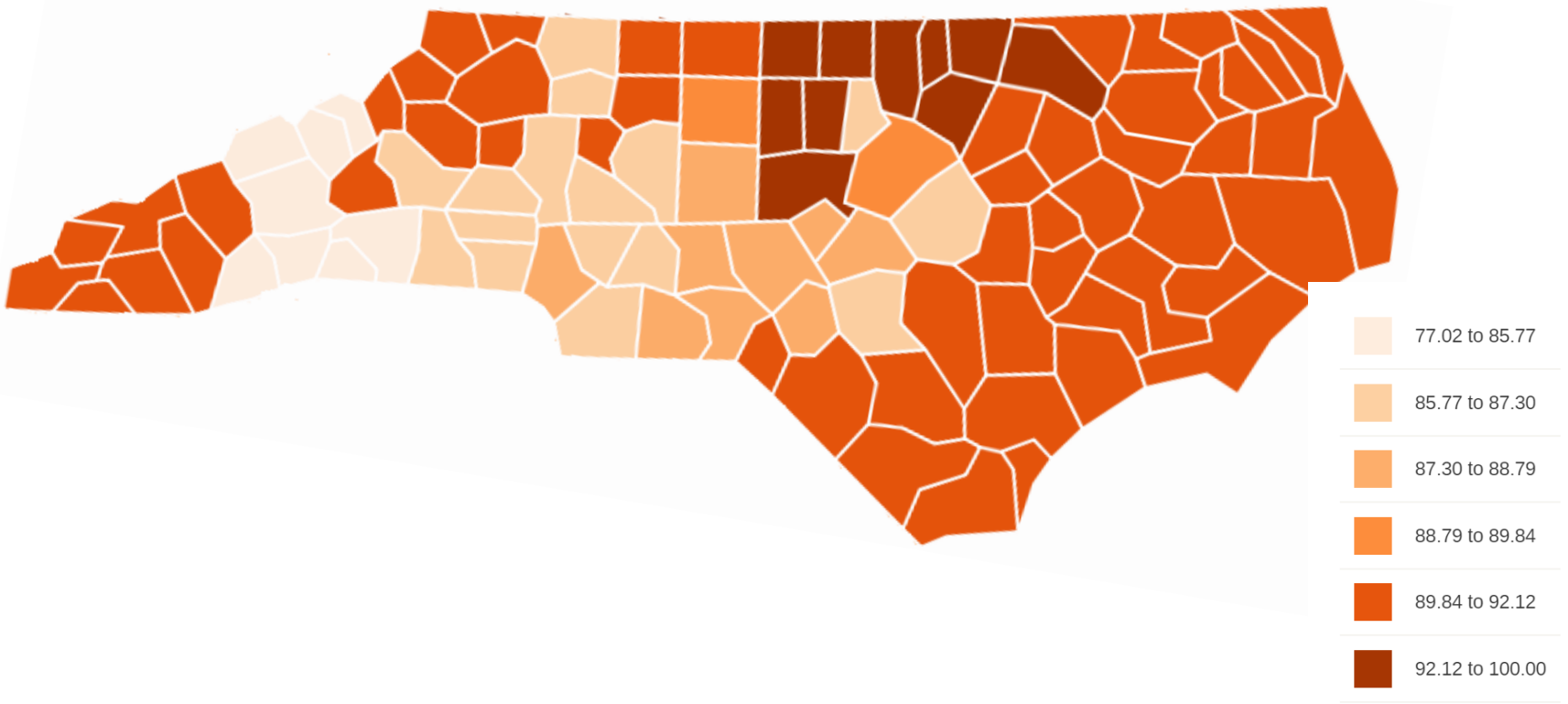
Elyse Powell

OUD Treatment Need and Capacity in NC

- **892** physicians waivered to prescribe buprenorphine
- NC ranks **9th** nationally in the number of facilities which offer MAT
- In 2012, NC had the capacity to treat **3 patients for every 10** people who reported past year opioid dependence

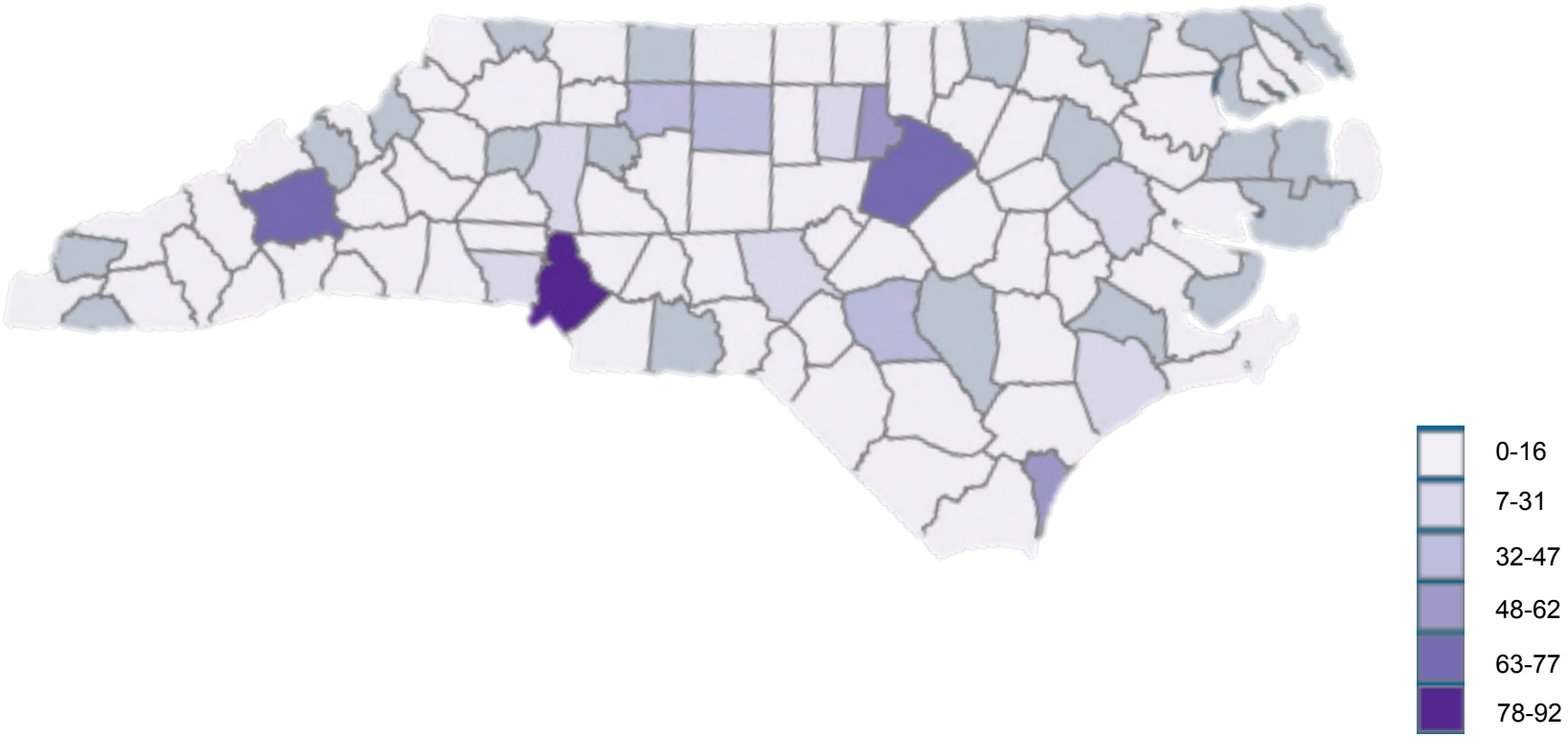
SOURCE: Jones et al., 2015

Percent of people needing but not receiving addiction treatment, 2014



NSDUH, 2014

Number of waivered physicians in NC, 2017



N-SSATS 2017

State Efforts to Increase OBOT Capacity

Sara McEwen

Medication Assisted Treatment for Opioid Use Disorder

- Strong evidence base for methadone, buprenorphine, naltrexone
- Offering these medications part of best practice, yet underutilized for several reasons:
  - Stigma
  - Lack of knowledge
  - Lack (or perceived lack) of access to expertise
  - Lack of logistical support

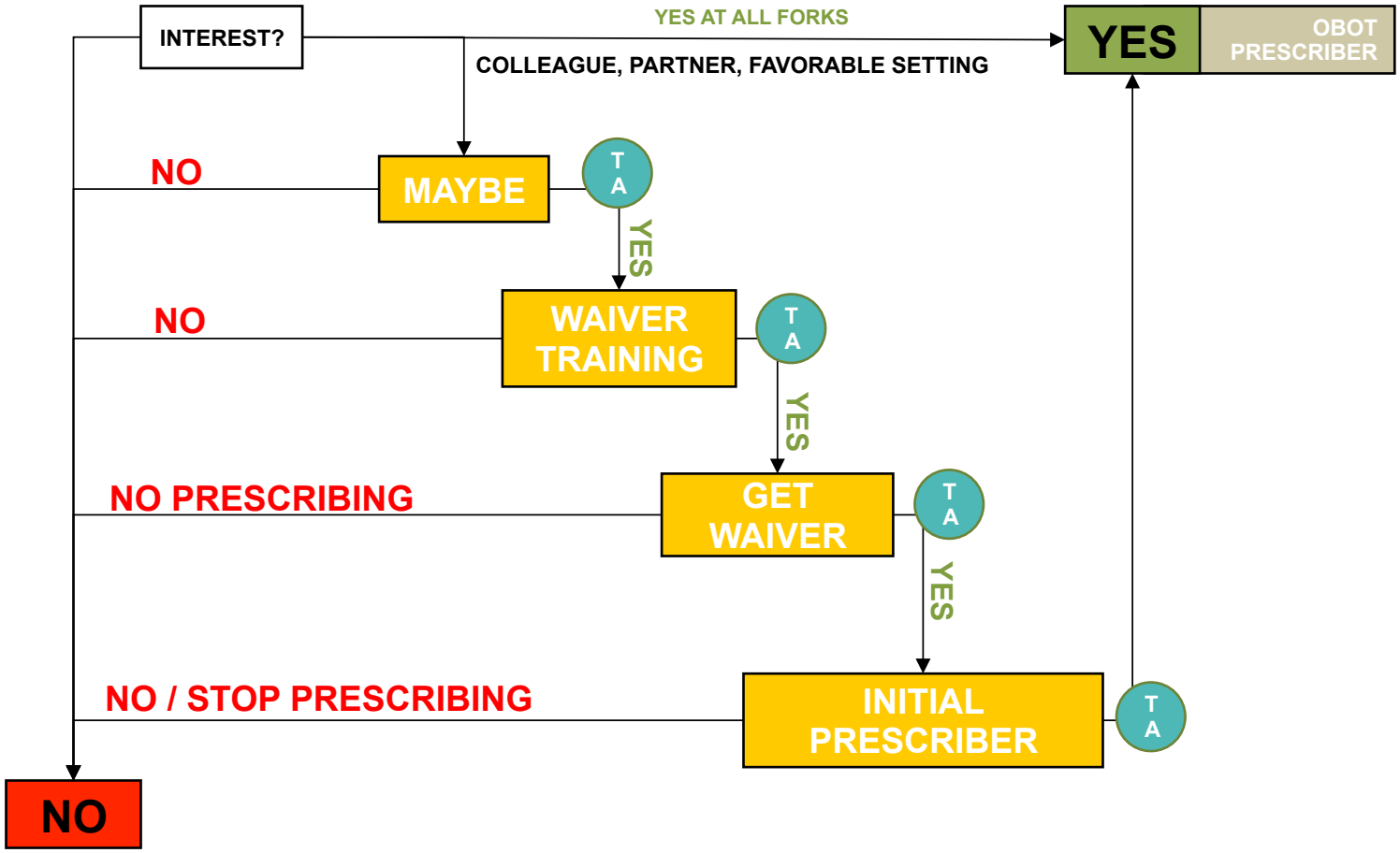
Why are Prescribers Hesitant to Provide OBOT services?

- Knowledge and skills
- Confidence
- But mostly, where the rubber hits the road
  - No access (real or perceived)to the specialty support they need. Different levels of support needed:
    - Mentoring/access to resources
    - Access to services that addiction medicine specialists provide:
      - Medical /Psychosocial: assessment, risk stratification, induction, stabilization, counseling, peer support
      - Logistical support: UDS, treatment agreements, CSRS surveillance
  - Other logistics: doesn't fit into work flow, staffing, paperwork/HER
  - Inadequate ROI in most primary care practice settings

Training/Technical Assistance

- Phase 1: Addiction 101 training, OBOT 101 TA
- Phase 2: Waiver-training
- Phase 3: Post waiver-training support TA
- TA to address:
  - Access to BH services
  - Access to mentor/colleague
  - Access to clinical expertise at point of care
  - Workflow redesign
  - Reimbursement/billing

Critical Junctures to Become OBOT PROVIDER



NC DHHS MAT Efforts

- Training on pain management/MAT for prescribers/ dispensers
- Support for waiver training (including in med/PA schools and residencies)
- Onsite technical assistance for primary care providers trying to implement safer opioid prescribing/MAT (obgyn, CCWNC/ MAHEC)
- Onsite technical assistance for primary care practice staff
- Learning collaborative/ongoing support for OTP providers: monthly call, regional meetings
- Access to one on one mentoring for OTP physicians
- Addiction Medicine Conference

NC DHHS MAT(cont'd)

- Support for NC COPE and other collaborations on medical education
- DMA doing its part: e.g. sublocade available without PA
- Support for GI to develop and maintain opioid and SUD oriented websites for physicians and other healthcare providers; includes statewide training list that serves as a master schedule
- MAT PDOA – MAT Project(SAMHSA discretionary grant)
- Cures/STR trainings: ASAM Criteria Skill building (2 day), ASAM Criteria Overview (1 day); Making MAT More Meaningful: Using EBPs to Promote Recovery (15 trainings across state in partnership with AHEC)
- Cures/STR: UNC ECHO expansion from 22 to 100 NC counties

Data Waivered Prescribers

- SAMHSA Data Waivered in NC (per posted list): 850
- SAMHSA Newly Data Waivered in NC by YEAR (Certified Physicians)

	Certified, 30 pts	Certified, 100 pts
2018	129	31
2017	362	41
2016	149	54
2015	89	53
2014	66	30
2013	56	39
2012	54	29
2011	57	21
2010	52	24
2009	38	21
2008	54	11
2007	57	40
2006	37	0
2005	56	0
2004	27	0
2003	20	0
2002	13	0

www.samhsa.gov/medication-assisted-treatment/physician-program-data/certified-physicians?field_bup_us_state_code_value=NC

Going Forward

- Continue training & educating (haven't saturated the market)
- Focus on implementation
  - Expand mentoring opportunities (NC ECHO)
  - STR Technical Assistance: SAMHSA and ATTC
- More active connecting of primary care physicians/prescribers to BH services/expertise a la medical model
- Focus on Add Med 101 and waiver training in medical/PA schools and residency programs
- Focus on specific populations and settings: e.g. corrections/ public safety/hospitals/EDs

Thank you

governorsinstitute.org/opioid

addictionmedicineupdates.org

Dr. Sara McEwen

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Overview of Other States' Regulations of OBOTs

Anna Stein

Kentucky

- **Dose and frequency of visits**
  - After induction, patient must be seen every ten days for the first month, every 2 weeks for the second month, and monthly thereafter for up to two years.
  - Can only prescribe enough buprenorphine to make it until the patient's next visit
  - Every 12 months, patients on more than 16 mg of buprenorphine/day must be referred for consultation to a physician who is certified in addiction medicine or psychiatry to determine if dosage is appropriate

Kentucky

- **Co-prescribing limitations**
  - If patient is also receiving benzodiazepines or other opioids, physicians must consult with a physician who is certified in addiction medicine or psychiatry before prescribing more than 30 days of buprenorphine
- **Behavioral health treatment**
  - Must have a treatment plan that includes “behavioral modification” by the patient, including counseling or 12-step program
- **Prescribers may not charge Medicaid members cash for outpatient buprenorphine treatment**

Ohio

- **Dose and frequency of visits**
  - To prescribe more than 16mg/day, prescribers must either be a board certified addiction psychiatrist or consult one in advance
  - During the first year, prescribers may only prescribe a 30 day supply.
  - During the first year, prescribers must meet with patients every 3 months
- **Ongoing drug screening**
  - During the first 6 months, patients must submit to monthly toxicology tests, with random screens every 3 months after that
- **Co-prescribing limitations**
  - If patient is receiving controlled substances from another prescriber, MAT prescriber most consult with a board certified addictionologist or addiction psychiatrist
- **Behavioral health treatment**
  - Patient must attend behavioral counseling or treatment services. If prescriber allows a 12-step program in lieu of professional treatment services, prescriber must document reason
  - Prescriber must have a treatment plan, which is updated each time they meet with the patient

Virginia

- **Dose and frequency of visits**
  - During induction, patients should not receive more than 8mg/day
  - During induction patient must meet with prescribers weekly
  - Patients may not be prescribed more than 24mg/day
  - "Prescribers must work to provide the lowest possible effective dose"
- **Ongoing drug screening**
  - Patient must submit to urine drug screens or serum medication levels every three months during the first year, and every six months after that
- **Co-prescribing limitations**
  - Buprenorphine may only be prescribed to patients with an opioid or benzodiazepine 'under extenuating circumstances' that must be documented
- **Behavioral health treatment**
  - All patients must 'be provided' counseling, either in house or through referral
- **Medicaid providers cannot charge cash for covered OBOT services**

Tennessee

- **Dose and frequency of visits**
  - To prescribe more than 20mg/day, prescribers must either be a board certified addiction specialist or “to the extent possible” consult one in advance.
  - To prescribe >16mg/day for more than 30 days, reason for the high dosage must be documented
  - Buprenorphine mono-product may only be prescribed to women that are pregnant or nursing, or have a documented adverse reaction to naloxone
- **Ongoing drug screening**
  - None
- **Co-prescribing limitations**
  - None
- **Behavioral health treatment**
  - No state requirement beyond federal requirement that physicians ‘must be able to refer patients to psychosocial support’

Tennessee- State Guidelines (2018)

- **Before prescribing**
  - Prescriber must establish a baseline measure to evaluate patients response
  - The controlled substance monitoring database must be checked
  - Prescriber must obtain a drug screen prior to treatment
- **Dose and frequency of visits**
  - In addition to state statutes, target buprenorphine range should be 6-12mg/day
  - During induction, provider should meet with patient weekly
  - During maintenance, provider should meet with patient every 2-4 weeks in the first year and every 2 months thereafter
- **Ongoing drug screening**
  - Ongoing drug screening should comply with ASAM's guidelines
- **Co-prescribing**
  - Patients with a benzodiazepine prescriptions may be prescribed MAT, but prescriber should coordinate care with the benzodiazepine prescriber
- **Behavioral health treatment**
  - Patient should receive counseling at least monthly during the maintenance phase
  - The provider shall be responsible for determining and documenting is receiving counseling
  - Providers should offer to make counseling appointments on the patient's behalf and coordinate care.

https://www.tn.gov/content/dam/tn/health/documents/2018%20Buprenorphine%20Tx%20Guidelines.PDF

ASAM: 2018 Public Policy Statement on the Regulation of OBOTs

Some recommendations:

- All regulation should be evidence-based
- States should consult with addiction specialists in designing regulations
- States should study regulations' effect on access to treatment
- Any licensing should be overseen by state board of medicine or department of health
- Providers who treat ≤100 patients should have no regulatory requirements beyond what is included in DATA 2000

Panel: Barriers & Success to NC OBOT Treatment

Larry Greenblatt, Jana Burson, Ashwin Patkar, & Steve Wyatt

Group Discussion

Wrap up, THANK YOU!, and What's next

- Next OPDAAC Coordinating Meetings
  - August 9 at NC Healthcare Association
  - October 9
  - November 8

- Next Full OPDAAC Meeting
  - June 22, 2018 at NC State McKimmon's Center