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

3 Oversight Agencies
0 Routine Inspections per year (for cause)
2 State/Federal Laws
1 ASAM Practice Guideline
Overview of Current OBOT Capacity, Regulations

Elyse Powell
OUD Treatment Need and Capacity in NC

- **892** physicians waived 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 waived 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:
    o Mentoring/access to resources
    o 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:
  o Access to BH services
  o Access to mentor/colleague
  o Access to clinical expertise at point of care
  o Workflow redesign
  o Reimbursement/billing
Critical Junctures to Become OBOT PROVIDER

- **INTEREST?**
  - **NO**
  - **MAYBE**
    - **T A**
  - **YES AT ALL FORKS**
    - **YES**
      - **OBOT PRESCRIBER**
    - **NO**
      - **NO PRESCRIBING**
        - **NO / STOP PRESCRIBING**
          - **NO**

- **COLLEAGUE, PARTNER, FAVORABLE SETTING**
  - **T A**
  - **WAIVER TRAINING**
    - **T A**
    - **YES**
      - **GET WAIVER**
        - **T A**
        - **YES**
          - **INITIAL PRESCRIBER**
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)

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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
sara@govinst.org
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’

• 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