Opioid Use Disorder & Medication Assisted Treatment Workshop

Saturday, October 28, 2017
The Public Health Impact of the Opioid Epidemic in the US and Maine

Dora Anne Mills, MD, MPH
Toho Soma, MPH
October 28, 2017
Deaths Due to Overdose in Maine, 2000-17

- **All Overdose Deaths**
- **Opioid Overdose Deaths**

+ **2000** 60
+ **2001** 55
+ **2002** 91
+ **2003** 86
+ **2004** 98
+ **2005** 116
+ **2006** 93
+ **2007** 102
+ **2008** 105
+ **2009** 114
+ **2010** 90
+ **2011** 85
+ **2012** 100
+ **2013** 125
+ **2014** 208
+ **2015** 272
+ **2016** 313
+ **2017** 370 (Projected)

**Source:** Maine Office of the Chief Medical Examiner and US Centers for Disease Control and Prevention
Opioid Overdose Mortality Rates per 100,000, 1999-2015 (Age-adjusted)

Source: Centers for Disease Control and Prevention
Opioid Overdose Deaths
by Age Group, 2015

Opioid Overdose Deaths in Maine by Age Group, 2015

- 0 to 24: 17 (7%)
- 25 to 34: 68 (29%)
- 35 to 44: 58 (24%)
- 45 to 54: 60 (25%)
- 55+: 35 (15%)

Total = 238

Opioid Overdose Deaths in the US by Age Group, 2015

- 0 to 24: 3,165 (9%)
- 25 to 34: 8,568 (26%)
- 35 to 44: 7,484 (23%)
- 45 to 54: 8,568 (26%)
- 55+: 6,277 (19%)

Total = 33,089

Source: Centers for Disease Control and Prevention
Number of Drug Deaths in Maine Involving Opioids*, 2012-2016

April 2017: First overdose death in Maine due to carfentanil

*Some deaths involve multiple types of opioids.
Source: Prescription Monitoring Program
Naloxone Administrations in Maine, 2012-2016

Source: Maine Office of the Chief Medical Examiner
Primary Treatment Admissions in Maine by Substance, 2016

- Alcohol: 3,552 (36%)
- Heroin/Morphine: 2,746 (28%)
- Other Opiates and Synthetics: 2,146 (22%)
- Other Substances: 1,321 (14%)

Total = 9,765

Source: Maine Web Infrastructure for Treatment Services (WITS)
DEA Drug Offense Arrests in Maine, 2007-2015

Source: Maine Drug Enforcement Agency
Heroin Use in Maine in the Past Year, by Age Group, 2014-15

- Total = ~6,800
- 18 to 25 years old
  - ~1,500
  - 22%
- 26 and older
  - ~5,100
  - 75%
- 12 to 17 years old
  - ~200
  - 3%

Source: National Survey on Drug Use and Health
Maine Infants Born Drug Affected, 2012-2016

Babies Born Drug Affected

- 2012: 779 (6.1% of all live births)
- 2013: 927 (7.4% of all live births)
- 2014: 961 (7.8% of all live births)
- 2015: 1,013 (8.1% of all live births)
- 2016: 1,024 (8.1% of all live births)

Source: Maine Office of the Chief Medical Examiner
Past Year Non-Medical Use of Prescription Pain Relievers in Maine

- **12 to 17 years old**:
  - 2011-12: 14,000 (11.0%)
  - 2012-13: 11,000 (8.9%)
  - 2013-14: 9,000 (7.1%)

- **18 to 25 years old**:
  - 2011-12: 5,000 (5.1%)
  - 2012-13: 4,000 (4.3%)
  - 2013-14: 4,000 (4.1%)

- **26+ years old**: (percent and numbers not shown)

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**Source:** Maine Office of the Chief Medical Examiner
QUIZ TIME!

A. 675,000
B. 14,500,000
C. 36,000,000
D. 89,000,000
E. 131,000,000

1. Narcotic pills prescribed in Maine in 2015
2. Packages of LL Bean products shipped in 2016
5. Tourists visiting Maine in 2016
66.7 pills/Mainer * 1,329,328 Mainers in 2015 = 89 Million Pills in Maine in 2015
131 million pounds of lobster caught in Maine in 2016

36 million tourists visited Maine in 2016

675,000 gallons of maple syrup produced in Maine in 2016

14.5 million LL Bean packages shipped in 2016

131 million pounds of lobster caught in Maine in 2016
Opioid Prescriptions per 100 people, 2016

Prescriptions for Long Acting Opioids as a % of All Opioid Prescriptions, 2016

In Summary

• 1 overdose death per day
• Over 80% due to opioids
• New England and Central Appalachia
• Half are between 25 and 44
• Rise of Fentanyl and Carfentanil
• Half of treatment is for opioids
• More arrests for heroin than Rx opioids
• Rx opioid misuse is decreasing
• But still 89,000,000 pills
• Long Acting Opioids
Resources

• Maine Statewide Epidemiological Outcomes Workgroup (SEOW)
  • http://www.maineseow.com

• Annual Surveillance Report of Drug-related Risks and Outcomes, 2017
Remember why we’re here

Source: Portland Press Herald
Thank you!

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Stigma and Language When Discussing Substance Use Disorder

Matthew Braun – Young People in Recovery

University of New England
OUD & MAT Conference

October 28, 2017
What the Stats Say

- **General Public**
  - A majority of Americans (63%) have been affected by addiction
  - A majority (67%) believe that there is a stigma toward people in recovery
  - A majority (74%) say that attitudes & policies must change

*So why aren’t things changing??*

- **Recovery Community**
  - 88% believe it is very important for the American public to see that thousands get well every year

Addiction may be most stigmatized condition in the US and around the world: Cross-cultural views on stigma

Across 14 countries and 18 of the most stigmatized conditions…

Illicit drug addiction ranked 1st

Alcohol addiction ranked 4th

Stigma, social inequality and alcohol and drug use

ROBIN ROOM

Centre for Social Research on Alcohol and Drugs, Stockholm University, Stockholm, Sweden

• Sample: Informants from 14 countries
• Design: Cross-sectional survey
• Outcome: Reaction to people with different health conditions
• Year of study: 2005
Relationship Between Cause and Controllability in Producing Stigma

Controllability

Cause

"Can't help it"

"NOT their own fault"

"IS their own fault"

Extent of Stigma
Despite increased agreement that alcohol addiction is biomedical, more viewed it also as due to “bad character”

Thus, while emphasizing biomedical, need to talk about addiction as treatable disorder, recovery is likely…
“Words have immense power to wound or to heal... The right words catalyze personal transformation and offer invitations to citizenship and community service. The wrong words stigmatize and dis-empower.”

~William White
Author
40 year researcher
“The Historian of the Recovery Movement”

Check out his writing on www.williamwhitepapers.com
<table>
<thead>
<tr>
<th>Instead of:</th>
<th>Try:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addict</td>
<td>Person with a substance use disorder</td>
</tr>
<tr>
<td></td>
<td>Person with a serious substance use disorder</td>
</tr>
<tr>
<td>Addicted to X</td>
<td>Has an X use disorder</td>
</tr>
<tr>
<td></td>
<td>Has a serious X use disorder</td>
</tr>
<tr>
<td></td>
<td>Has a substance use disorder involving X (if more than one substance is involved)</td>
</tr>
<tr>
<td>Addiction</td>
<td>Substance use disorder</td>
</tr>
<tr>
<td></td>
<td>Serious substance use disorder</td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td></td>
</tr>
<tr>
<td>• “Addiction” is appropriate when quoting findings or research that used the term or if it appears in a proper name of an organization.</td>
<td></td>
</tr>
<tr>
<td>• “Addiction” is appropriate when speaking of the disease process that leads to someone developing a substance use disorder that includes compulsive use (for example, “the field of addiction medicine,” and “the science of addiction”).</td>
<td></td>
</tr>
<tr>
<td>• It is appropriate to refer to scheduled drugs as “addictive.”</td>
<td></td>
</tr>
<tr>
<td>Alcoholic</td>
<td>Person with an alcohol use disorder</td>
</tr>
<tr>
<td></td>
<td>Person with a serious alcohol use disorder</td>
</tr>
<tr>
<td>Alcoholics Anonymous / Narcotics Anonymous / etc.</td>
<td><strong>Note:</strong> When using these terms, take care to avoid divulging an individual's participation in a named 12-step program.</td>
</tr>
<tr>
<td>Clean</td>
<td>Abstinent</td>
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<tr>
<td>Instead of</td>
<td>Try:</td>
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<td>--------------------------------------------------</td>
<td>--------------------------------------------------------</td>
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<tr>
<td>Clean Screen</td>
<td>Substance-free</td>
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<tr>
<td></td>
<td>Testing negative for substance use</td>
</tr>
<tr>
<td>Dirty</td>
<td>Actively using</td>
</tr>
<tr>
<td></td>
<td>Positive for substance use</td>
</tr>
<tr>
<td>Dirty Screen</td>
<td>Testing positive for substance use</td>
</tr>
<tr>
<td>Drug habit</td>
<td>Substance use disorder</td>
</tr>
<tr>
<td></td>
<td>Compulsive or regular substance use</td>
</tr>
<tr>
<td>Drug/Substance Abuser</td>
<td>Person with a substance use disorder</td>
</tr>
<tr>
<td></td>
<td>Person who uses drugs (if not qualified as a disorder)</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> When feasible, “Drug/Substance Abuse” can be replaced with “Substance Use Disorder.”</td>
</tr>
<tr>
<td>Former/reformed Addict/Alcoholic</td>
<td>Person in recovery</td>
</tr>
<tr>
<td></td>
<td>Person in long-term recovery</td>
</tr>
<tr>
<td>Opioid Replacement or Methadone Maintenance</td>
<td>Medication assisted treatment</td>
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<tr>
<td></td>
<td>Medication-assisted recovery</td>
</tr>
<tr>
<td>Recreational, Casual, or Experimental Users (as opposed to those with a use disorder)</td>
<td>People who use drugs for non-medical reasons</td>
</tr>
<tr>
<td></td>
<td>People starting to use drugs</td>
</tr>
<tr>
<td></td>
<td>People who are new to drug use</td>
</tr>
<tr>
<td></td>
<td>Initiates</td>
</tr>
</tbody>
</table>

Table source: White House Office of National Drug Control Policy; The Huffington Post

**STOP TALKING ‘DIRTY’: CLINICIANS, LANGUAGE, AND QUALITY OF CARE FOR THE LEADING CAUSE OF PREVENTABLE DEATH IN THE UNITED STATES**

John F. Kelly, PhD
Sarah E. Wakeman, MD
Richard Saitz, MD

**EDITORIAL**

Language, Substance Use Disorders, and Policy: The Need to Reach Consensus on an “Addictionary”

John F. Kelly PhD, Richard Saitz MD & Sarah Wakeman MD
Language in a Clinical Setting

- 500 doctoral-level clinicians exposed to a vignette:
  - a man was mandated to treatment
  - he had used drugs/alcohol for the past few
  - the program required abstinence
  - he agreed to comply with program requirements and
  - 30 days in was found with 2 positive urinalyses
  - now awaits his appointment with the judge for determination
  - in half of the group, man is labeled as “person with substance use disorder” and in the other a “substance abuser”

- “Substance abuser”
  - clinicians more likely to judge the person as deserving of blame and punishment
  - clinicians more likely to deny treatment
Language and attitudes create cognitive implicit bias and influence discriminatory practices and policies. These are severely impeding society’s progress on these issues.

What is Recovery

- A process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. ~ SAMHSA, 2012

- **Health**: overcoming or managing one’s disease(s) or symptoms…and making informed, healthy choices that support physical and emotional wellbeing.

- **Home**: a stable and safe place to live.

- **Purpose**: meaningful daily activities (e.g. job, school, volunteerism, etc.) and the independence, income and resources to participate in society.

- **Community**: relationships and social networks that provide support, friendship, love, and hope.
“LIFE IN RECOVERY”
Report on the Survey Findings

Prepared by Alexandre Laudet, Ph.D.
for Faces & Voices of Recovery

FACES & VOICES OF RECOVERY
FACESANDVOICESOFRECOVERY.ORG

APRIL 2013
HEALTH: NEGATIVE

- Frequent emergency room visits (other than for any ongoing medical / mental condition)
- Had no health insurance
- Frequent use of health care services (e.g. hospitals, clinics, detox)
- Contracted infectious disease (e.g. Hep C or HIV/AIDS)
- Experienced untreated emotional / mental health problems

Legend:
- IN ACTIVE ADDICTION (% Yes)
- < 3 YEARS IN RECOVERY
- 3 TO 10 YEARS IN RECOVERY
- > 10 YEARS IN RECOVERY
HEALTH: POSITIVE

- Took care of my health, e.g. got regular medical checkups, sought help if needed
- Got regular dental checkups
- Had primary care provider
- Exercised regularly
- Had healthy eating habits: POSITIVE nutrition

Legend:
- IN ACTIVE ADDICTION (% Yes)
- < 3 YEARS IN RECOVERY
- 3 TO 10 YEARS IN RECOVERY
- > 10 YEARS IN RECOVERY
Implications of these data

- A shift from active use to active recovery is good for individuals, families, communities, and the nation’s health and economy

- We need to start using the benefits of recovery (not the magnitude of the problem) as a means to help ameliorate the problem
Video Clip
What Can We Do about Stigma and Discrimination in Addiction?

- Change our language/terminology to be consistent with true medical nature of condition and policies we wish to implement…
  - Implicit bias is a powerful thing
- Stress that SUDs are treatable and recovery is a reality
- Solution-oriented emphasis instead of problem-oriented
- Personal witness - putting a face and voice on recovery
- Become the vocal majority
Core Message for a Provider/Ally

- I work with/interact with this group/person, who is a part of our community, living in long term recovery…

- Recovery has brought stability to [his/her] life

- They are part of a community that helps empower and enhance our community experience

- Long-term recovery has given them and our community new purpose, creating a culture of support and assistance.

- Our program makes it possible for all to find an enhance quality of life, while pursuing personal goals and successes
Thank you for being a change agent!!!

Please reach out with questions, concerns, or comments

matthew.carl.braun@gmail.com

(207) 776-0420
Early Intervention Screening and Prevention Methods for Patients with Potential Substance Use Disorders

October 28, 2017
OUD and MAT conference
Portland, ME

Clay Graybeal, Ph.D., M.S.W.
Bethany Fortier, M.P.H.
Brianna Nalley, M.P.H.
University of New England
University of New England: IPEC
Interprofessional Education Collaborative
Founded in May 2010

- Core IPE curriculum
- Team Immersion
- Student-led Mini-Grants
- IP Honors Distinction
- Clinical Education Sites
- Faculty Development
- Service Learning
- SBIRT
SBIRT

Screening, Brief Intervention, & Referral for Treatment

An evidence-based, comprehensive and integrated public health approach for early identification and intervention with patients whose alcohol and/or drug use patterns put their health at risk.
SBIRT at UNE

SAMHSA: *Collaborative SBIRT Training for Maine’s Future Health Care Leaders*

$290k/year for three years

Program Director: Clay Graybeal, Ph.D., M.S.W.
Program Manager: Kris Hall, M.F.A.
Program Assistant: Brianna Nalley, M.P.H.

Model

- Educate approx. 320 students per semester in basic SBIRT conceptual model and components
- Educate and train 64 students per semester to become Student Leaders in SBIRT
- Train clinical preceptors and field instructors in SBIRT
- Provide all student leaders with the opportunity to implement in clinical setting with supervision and feedback
Identifying & Training Student Leaders

• Enlist 64+ student leaders from 8-10 programs

• Requirements include training in three components:
  1. Motivational Interviewing
  2. Interprofessional Education
  3. Leadership Development

• Opportunity to implement in the field with informed preceptor or field instructor
SBIRT Components Include:

- **Universal and Annual Screening (S):** Identifies unhealthy use.

- **Brief Intervention (BI):** Provides feedback about unhealthy substance use.

- **Referral to Treatment (RT):** Helps facilitate access to addiction assessment and treatment.
Research Demonstrates Effectiveness

“Brief interventions are feasible and highly effective components of an overall public health approach to reducing alcohol misuse.”

(Whitlock et al., 2004, for U.S. Preventive Services Task Force)
When and where do we start?

“When” = Universal Screening
Increase comfort using it whenever appropriate!

“Where” = Any Appropriate Healthcare Setting
All healthcare professionals should be comfortable addressing SUDs.
Screening

**Screening tool examples:**
BAC (or other medical tests such as liver function)

**AUDIT**

ASSIST

DAST

CRAFFT

T-ACE/TWEAK

4 or 5 P’s

CAGE (may fail to detect low but risky levels of drinking)
Paper vs. Interview: AUDIT Skills Practice

Complete screen and AUDIT as self-report.

- Do you have enough information to respond?
- What would you ask to get more, if needed?
<table>
<thead>
<tr>
<th>Score</th>
<th>Risk Level</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7</td>
<td>None - Low</td>
<td>Education/ Affirmation</td>
</tr>
<tr>
<td>8-15</td>
<td>Hazardous or Harmful</td>
<td>Brief Intervention</td>
</tr>
<tr>
<td>16-19</td>
<td>Higher level of problems</td>
<td>Brief Intervention, Intensive Intervention, Monitoring</td>
</tr>
<tr>
<td>20-40</td>
<td>Possible dependence</td>
<td>Referral to specialist for evaluation and possible treatment</td>
</tr>
</tbody>
</table>
Targets for SBI?

Note: represents the general adult population in the US. The % of high-risk drinkers is likely to be much higher in certain settings such as emergency or trauma units.
Brief Intervention

A brief motivational and awareness-raising intervention given to risky or problematic substance users.

Steps of BI:
1) Build rapport
2) Provide information and/or feedback
3) Build readiness to change
4) Negotiate a plan for change
Motivational Interviewing Principles

Develop **DISCREPANCY**
Between goals and values

Express **EMPATHY**
Through reflective listening

Avoid **ARGUMENT**
No direct confrontation

Roll with **RESISTANCE**
Adjust rather than oppose

Support **SELF-EFFICACY**
Maintain optimism


SAMHSA: Enhancing Motivation for Change in Substance Abuse Treatment - Chapter 3, Motivational Interviewing as a Counseling Style: https://www.ncbi.nlm.nih.gov/books/NBK64964/#A61738
Core Motivational Interviewing Skills

✓ Open-ended questions
✓ Affirmations
✓ Reflections
✓ Summaries
Demonstration
Let’s Practice!
Referral for Treatment:
Connecting patients and clients to appropriate resources
Role of the Healthcare Professional in SBIRT

- Identification of use, misuse, and problematic use; screen with simple direct methods
- Connection of use/misuse to health related issues and feedback
- Consumption reduction
- Brief Intervention
- Referral for formal assessment
Warm Handoff: Best Approach to a Successful Referral for Treatment

• Describe treatment options to patients based on available services and what the patient wants or is willing to do

• Develop relationships with specialty addiction services and local recovery coaches
A Final Observation

Substance use issues play a key role in the health of individuals and communities, and we believe that intervention can occur in event the briefest encounter with a sensitive, caring, and professional health care provider.
Early Intervention Screening and Prevention Methods for Patients with Potential Substance Use Disorders

Clay Graybeal, Ph.D., M.S.W.
Bethany Fortier, M.P.H.
Brianna Nalley, M.P.H.
sbirt@une.edu

Questions?
Laws and Regulations in Maine re: Prescribing and Dispensing Opioids and Opioid Antagonists

Peter P. Michaud, JD, RN
Maine Medical Association

University of New England, Portland, Maine
October 28, 2017
Disclosure

“There are no significant or relevant financial relationships to disclose.”
Opioids: the difficult truth

“We know of no other medication routinely used for a nonfatal condition that kills patients so frequently.”

NEJM: 374;16 4-21-16

Dosage >200 MME: Number Needed to Kill = 32
More than One Death per Day

- Maine leads nation in rate of long-acting opioid prescriptions
- Overdose death rate in Maine increased 40% from 2015 to 2016
- 272 Mainers lost to opioid/heroin deaths in 2015
- 376 overdose deaths in 2016 (313 involving opioids)
- 180 overdose deaths in first 6 months of 2017

Contrast: During the last decade, there were 258 homicides in Maine.
1,024 Maine Babies Drug Affected in 2016
1,013 in 2015

• Maine’s infant mortality rate (7.1/1000) exceeds the national average

• 1 out of every 11 babies in Maine was born drug-affected in 2016

• 3 drug affected babies born each day
Naloxone Administrations

- 1,565 in 2015
- 2,380 in 2016

Indications: respiratory or CNS depression
Maine Leads the Nation

• Maine leads the nation in prescribing long acting opioids at 21.8 Rx/100 people.
• 60 to 65 pills for every man, woman and child in Maine annually.
Evidence of Over-Prescribing

• C-Section patients\(^1\)
  • 53% report taking no or very few (<5) opioid pills prescribed post-operatively
  • 83% report taking half or fewer

• Thoracic surgery patients\(^1\)
  • 45% report taking no or very few (<5) opioid pills prescribed post-operatively
  • 71% report taking half or fewer

\(^1\): PLoS One 2016 29;11(1); e0147972. Epub 2016 Jan
Growing Evidence of Over-Prescribing

- **General surgery patients**
  - 75% partial mastectomy pts did not take any of their prescribed opioids
  - 34% lap choly pts took no prescribed opioids
  - 45% lap inguinal hernia pts took no prescribed opioids
  - Pts reported having 67% to 85% opioid pills remaining

- **Wisdom tooth extraction patients**
  - On average, received 28 pills but used <50% of amount prescribed
  - Extrapolates to >100 million opioid pills unused nationally!

How to stop an infection

• If you’re a healthcare provider:
  • Prescribe an antibiotic

• If you’re a legislator:
  • Make a law
Overview of P.L. 2015, Chapter 488

- As Amended by P.L. 2017, Chapter 213
- As further described by OSAMHS Rule Chapter 11, Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription Opioid Medications

Components include:

- Required PMP check for prescribers and dispensers
- Prescribing limits on MMEs per day
- Prescribing limits on length of scripts
- Exception for emergency rooms, inpatient hospitals, long-term care facilities, or residential care facilities or in connection with a surgical procedure.
- Exception for medication-assisted treatment for substance use disorder
- Exceptions for active and aftercare cancer treatment, palliative care, and end-of-life and hospice care
- Other exceptions may be determined by rule
- Mandatory CME
- Mandatory electronic prescribing
- Partial filling of prescriptions at patient request
Key Definitions

• **Acute pain**
  • Normal, predicted physiological response to a noxious chemical or thermal or mechanical *stimulus*
  • Typically associated with invasive procedures, trauma or disease and is usually time-limited

• **Chronic pain**
  • *Persists* beyond the usual course of an acute disease or healing of an injury
  • May or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years
Key Definitions

- **Opioid medication**
  - A controlled substance containing an opioid; includes tramadol, does not include loperamide

- **Prescriber**
  - Licensed health care professional with authority to prescribe controlled substances
  - Includes MDs, DOs, PAs, NPs, podiatrists, dentists, and veterinarians

- **Administer**
  - Action to apply prescription drug directly to a person by any means by a licensed or certified health care professional (the statute and rule do not define “order”, as in ordering a medication to be administered by an RN)
  - Does not include delivery, dispensing, or distribution of a prescription drug for later use
Key Definitions

• **Palliative care**
  • Patient-centered, family-focused medical care that optimizes quality of life by anticipating, preventing, and treating suffering caused by serious medical illness or physical injury or condition that substantially affects quality of life
  • Addresses physical, emotional, and social needs
  • Facilitates patient autonomy and choice of care
  • Provides access to information
  • Discusses patient’s goals for treatment and treatment options, including hospice care, when appropriate
  • Manages pain and symptoms comprehensively
  • Palliative care does not always include a requirement for hospice care or attention to spiritual needs. (new)
  • Note: Does NOT require a terminal condition
Key Definitions

• **Serious illness**
  
  • Medical **illness** or physical **injury** or **condition** that substantially affects quality of life for more than a short period of time
  
  • Includes, but is not limited to, Alzheimer’s disease and related dementias, lung disease, cancer and heart, renal or liver failure and chronic, unremitting or intractable pain such as neuropathic pain. (new)
Prescriber Responsibilities

- **Required PMP check**
  - Upon initial prescription of benzodiazepine or opioid medication
  - Every 90 days following

- **Delegation of PMP check**
  - Prescribers may delegate PMP check to “any staff member duly authorized” by prescriber and PMP Office
  - **Despite delegation, prescriber must review** patient’s aggregate MME (including new prescription); number of prescribers currently prescribing controlled substances to patient; and number of pharmacies currently dispensing same

- **Exception**
  - No PMP check is required for benzodiazepine or opioid medication directly administered in an emergency room setting, an inpatient hospital setting, a long-term care facility (assisted living or nursing home), or a residential care facility, or in connection with a surgical procedure
  - No PMP check is required for hospice or end-of-life patients
Prescriber Responsibilities

- **Continuing Education**
  - Every prescriber must complete 3 hours of CME on the prescription of opioid medication every 2 years as a condition of prescribing opioid medication
  - First 3 hours must be completed by 12/31/2017.

- **Electronic Prescribing**
  - Prescribers with the capability to electronically prescribe must prescribe all opioid medication electronically
  - A waiver may be available in some circumstances:
    - Written waiver application required
E-prescribing Mandate - Exceptions

- Waiver applications now available
  - Pharmacists not required to verify waivers or exceptions
- Exceptional circumstances allowing written prescriptions:
  - Temporary technological or electrical failure
  - To be dispensed by VA or Indian Health Service pharmacy, or outside Maine
  - Prescriber reasonably determines that it would be impractical, patient could not obtain medication timely, and delay would adversely impact patient’s medical condition
  - Long term care facilities may use fax per DEA rules
  - For homeless patients, use address of shelter, street name, if possible; if no address, may prescribe on paper
- **Note:** Exemption from limits/PMP checks is NOT exemption from E-prescribing requirement!
Prescriber Responsibilities

- Required notations on opioid prescriptions
  - Note prescriber’s DEA number
  - Note “Acute” or “Chronic” on the prescription (including suboxone) under 100 MME, or Exemptions “F” or “H” only
  - On prescriptions for “acute on chronic” pain (Exemption Code F), use “Acute”
  - On prescriptions for palliative care (Exemption Code B), note the diagnosis (ICD-10) code
  - On any prescriptions where an exemption is claimed, the exemption code (A through H) must be noted
  - Exemption codes are not required on veterinary prescriptions
  - New: Pharmacists may contact prescribers by telephone to verify and document missing information on the script.
Exemptions to limits on opioid medication prescribing

By Statute

1. Pain associated with active and aftercare cancer treatment. Providers must document in the medical record that the pain experienced by the individual is directly related to the individual’s cancer or cancer treatment. Exemption Code A

2. Palliative care in conjunction with a serious illness (includes injury). Code B, (ICD 10 Code must be included on script as well as “Code B”) 

3. End-of-life and hospice care. Code C 

4. Medication-Assisted Treatment for substance use disorder. (Original 12-month limit has been removed.) Code D
Exemptions to limits on opioid medication prescribing

By Rule

5. A pregnant individual with a pre-existing prescription for opioids in excess of the 100 Morphine Milligram Equivalent aggregate daily limit. This exemption applies only during the duration of the pregnancy. Code E

6. Acute pain for an individual with an existing opioid prescription for chronic pain. In such situations the acute pain must be postoperative or new onset. The seven day prescription limit applies. Code F

7. Individuals pursuing an active taper of opioid medications, with a maximum taper period of six months, after which time the opioid limitations will apply, unless one of the additional exceptions in this subsection apply; or Code G

8. Individuals who are prescribed a second opioid after proving intolerant to a first opioid, thereby exceeding the 100 MME limit. Neither prescription may exceed 100 MME. Code H
Partial fill

- Upon patient request, pharmacist may dispense *lesser* quantity of medication than is prescribed
- **Remainder** of prescription is **void**
- Pharmacist must, within 7 days, **notify** prescriber of quantity actually dispensed
- Notification may be by notation in patient’s EHR, by electronic transmission or fax or telephone
- In cases of pharmacist shortage, lesser quantity may be dispensed. Remainder may be dispensed only if within 72 hours.
Penalties

• Civil violation
• Subject to fine of $250 per incident up to a maximum of $5000 per calendar year
• More serious concern is Licensing Board action
  • PMP will report violations to Board, prescriber will receive 2 weeks’ advance notice and opportunity to comment
What will the Maine CDC Be Looking For?

- High number of prescribers in a short time
- High number of doses in a short time
- Days’ supply of prescriptions for the same drug overlapping by more than a few days
- Inappropriate combinations of controlled substances
- More than one method of payment within a short time
- More than one out-of-state prescriber for the same patient, within a short time
- More than one pharmacy on the same day
- More than one pharmacy in different public health districts within one month
- Dangerous levels of specific drugs
Other Provisions

• Prescription Monitoring Program (PMP)
  • PMP data access to other states and Canadian provinces (coming)
  • Automatic registration of pharmacists and veterinarians
  • “Enhancements” (New software: Appriss “PMP AWARxE®”)
    • “Dosage converter” to/from MME
    • Automatic distribution of de-identified peer data to prescribers annually
    • Improved delegation to non-prescriber staff
    • Improved speed and communication

• MaineCare rules
  • Limit of 4 acute pain prescriptions (28 days)
  • Then care is assumed to be for chronic pain
Naloxone

- **May be dispensed** by prescription, standing order, or collaborative practice agreement
  - To individual, family, friend, or “other person in a position to assist”
- Pharmacists may **prescribe** (until July 1, 2019) & dispense
- Law enforcement & fire departments may **obtain & administer** intranasal
- Community based overdose prevention programs may **obtain, administer, and distribute**
- **Legal immunity** for prescribing, dispensing, or administering
Still to Come

- Licensing Boards: Joint Rule Ch. 21 new & proposed amendments
  - Universal opioid precautions (exception for genuine medical emergency)
  - Risk assessment tool “encouraged”, assessment must be documented
  - Use measuring tools to assess level of pain, function, quality of life
  - Random toxicological drug screens required at least annually
    - Frequency based on patient’s level of risk
  - Random pill counts “an additional tool”, not mandatory
  - Treatment agreement, informed consent rules detailed & mandatory
  - Mandatory CME requirement to be broadened to all MDs (only), regardless of whether opioids are prescribed. Does not apply to any other prescribers.
Resources

MMA’s Opioid Crisis page:
- Opioid laws & rules, Maine Opiate Collaborative task force Reports, CDC guidelines, naloxone, Q and A, DHHS clarifications.

Caring for ME page:
- [https://www.mainequalitycounts.org/page/2-1488/caring-for-me](https://www.mainequalitycounts.org/page/2-1488/caring-for-me)
- Webinars, opioid laws & rules, information on pain management and tapering, etc.
Questions?

Maine Medical Association
30 Association Drive, P.O. Box 190
Manchester, Maine 04351
207-622-3374
207-622-3332 Fax

Gordon Smith, Esq. gsmith@mainemed.com
Andrew MacLean, Esq. amaclean@mainemed.com
Peter Michaud, Esq. pmichaud@mainemed.com
Objectives

• Recognize addiction as chronic condition, & MAT as effective treatment
• Review current landscape of MAT services available in Maine
• Understand utility of offering MAT services in primary care, including barriers & models
• Outline steps for increasing MAT capacity in primary care
Since 1999, sales of prescription opioids in the U.S. have quadrupled.
From 1999 to 2014, more than 165,000 people died from overdose related to prescription opioids.
National Overdose Deaths
Number of Deaths from Opioid Drugs

Source: National Center for Health Statistics, CDC Wonder
Maine’s Opioid Crisis: A Rising Death Toll!

ME Drug-Related Deaths

376 deaths in 2016

*2017 number projected, with 185 deaths as of 6/30/17
Nearly 400 Mainers Now Lost Each Year...

David McCarthy - 29 yo  
Coleen Singer – 32 yo  
David Zysk – 33 yo
Over 1000 Maine Babies Impacted at Birth Each Year

• 1 in 11 babies (1013) in Maine born drug-affected in 2015

• Maine’s infant mortality rate (7.1/1000) above national average, and climbing
What If... Imagine the Headlines?

376 Mainers Die of Flu...

376 Mainers Killed by Ebola virus...

Over 1000 Maine Babies Sickened by Environmental Toxin...
Facing Our Opioid Hurricane
Addressing the Crisis: Building a Comprehensive Approach

- Education/Prevention/Harm Reduction
- Treatment
- Law Enforcement

Effective Response
The Role of Clinicians & Practice Teams?

- Education/Prevention/Harm Reduction
- Treatment
- Law Enforcement

Effective Response
Clinicians & Practice Teams: Spectrum of Action

1. Prevent opioid addiction
2. Improve chronic pain management; shift focus from eliminating pain to improving function
3. Improve safety of opioid prescribing
4. **Screen for & recognize addiction where it exists**
5. **Offer treatment for addiction**
6. Promote harm reduction (e.g. naloxone)
Fundamental Questions:

Do you believe...
Diabetes is a disease?
Drug addiction is a disease?
Disease Definition:

• “An interruption or cessation or disorder of bodily functions, system or organ illness

• A morbid entity characterized by at least two criteria:
  – a recognizable agent
  – an identifiable group of signs or symptoms, or consistent anatomical alterations”

* Steadman’s Medical Dictionary
## Comparative Concepts

<table>
<thead>
<tr>
<th>Disease Element:</th>
<th>Diabetes</th>
<th>Addiction</th>
</tr>
</thead>
</table>
| Disorder of systems or organs | Pancreatic islet cells | Brain:  
  • Nucleus acumbens (reward)  
  • Orbitofrontal cortex (motivation)  
  • Amygdyla & hippocampus (memory)  
  • Prefontal cortex (cognitive control) |
| Disorder of fxn | Glucose uptake | Dopamine release |
| Identifiable group of signs & sx | Hyperglycemia: oliguria, thirst, fatigue, wgt loss | Intense, all-consuming drug cravings |
| Consistent anatomical alterations | Long-term diabetes complications: vascular disease; neuropathy; nephropathy | Brain remodeling |
Defining Addiction

• “A chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences

• Considered a brain disease because drugs change the brain... structure and how it works... that can be long lasting and lead to many harmful, self-destructive behaviors”*

*NIH National Institute of Drug Abuse
Fundamental Questions:

Should addiction be treated?
Can addiction be treated effectively?
Medication Assisted Therapy (MAT)

• Use of FDA-approved opioid agonists and antagonist medications, *in combination with* counseling and BH therapies

• Strong evidence for effectiveness of both methadone & buprenorphine

• Huge gaps in MAT treatment:
  – ~5 million Americans suffer from opioid addiction
  – <1 million currently receiving MAT*

MAT Medications

• Methadone: opioid agonist
  – Use restricted to specialized Opioid Tx Programs; requires supervised daily dosing

• Buprenorphine (Subutex): partial agonist
  – Requires “X-waiver” to DEA license; tablets

• Buprenorphine (partial agonist)/Naloxone (antagonist) (Suboxone)
  – Requires DEA X-waiver; admin’d as SL tablets/film

• Naltrexone (Vivitrol): antagonist
  – No special license required; can be administered via monthly IM injections
Suboxone

• Mixed opioid partial agonist/antagonist (buprenorphine) & opioid antagonist (naloxone)
• Buprenorphine dramatically reduces opioid craving lowers depression, anxiety (“feel normal”)
• Assoc’d with lower level of physical dependence
• Reduced potential for toxicity and overdose
• Naloxone only active intravenously – can precipitate opioid withdrawal if injected
Buprenorphine Effectiveness

• Reduces illicit drug use*
• Improves retention in drug treatment
• Strong evidence for improved patient function, outcomes

* Cochrane Review, Feb 2014
Buprenorphine Dramatically Improves Treatment Success

Approx. 75% of sample retained in maintenance
All participants who were medically withdrawn (control) dropped out of study by 60 days

(20% of control group died)

(Kakko et al., 2003)
Social Outcomes of Treatment

![Bar graph showing social outcomes of treatment before and after treatment.]

Data courtesy of David Roll, M.D., Cambridge Health Alliance, slide courtesy of Steve Martin, MD.
Buprenorphine Prescribing in Primary Care

- DEA requires “Drug Addiction Treatment Act (DATA) 2000 waiver” - i.e. “X-waiver” to DEA license
- X-waiver historically limited to physicians → changed with CARA 2016, allowing NPs & PAs to prescribe
  - MDs/Dos require 8-hour class on addiction treatment
  - PAs, NPs need to complete 24-hr course
- Prescribers limited to treating 30 pt’s at time for 1\textsuperscript{st} yr
- After 1 year, can apply to increase to 100 patients
  - DHHS rule change in 2016 allows addiction specialists and others meeting criteria to treat up to 275 pts
MAT in Primary Care

Huge disconnect among primary care providers between need for treatment & willingness to tx:

• Is it **important** to treat opioid addiction in the primary care setting?
  ➢ 92% agree

• Are you **confident** about treating opioid addiction in the primary care setting?
  ➢ 3% agree

Data courtesy of Steve Martin MD, citing Joji Suzuki, M.D., Brigham & Women’s Hospital, Phyllis Jen Cntr for Primary Care
MAT in Primary Care

Individuals with Select Medical Conditions Who Receive Treatment

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension&lt;sup&gt;1&lt;/sup&gt;</td>
<td>77.2</td>
</tr>
<tr>
<td>Diabetes&lt;sup&gt;2&lt;/sup&gt;</td>
<td>72.9</td>
</tr>
<tr>
<td>Major Depression&lt;sup&gt;3&lt;/sup&gt;</td>
<td>71.2</td>
</tr>
<tr>
<td>Addiction&lt;sup&gt;3&lt;/sup&gt; (excluding Nicotine&lt;sup&gt;*&lt;/sup&gt;)</td>
<td>10.9</td>
</tr>
</tbody>
</table>

<sup>2</sup> All ages; Centers for Disease Control and Prevention. (2011).
<sup>3</sup> Ages 12 and older; CASA Columbia analysis of the National Survey on Drug Use and Health (NSDUH), 2010.
<sup>*</sup> Due to data limitations.

Slide courtesy of Steve Martin MD
Addiction Care Largely Disconnected from Mainstream Medical Practice

• No national standards for who may provide addiction treatment in the U.S.; varies by state and payer

• Most physicians and other health professionals do not identify or diagnose the disease or know what to do with patients who present with treatable symptoms

• No other disease where appropriate medical treatment is available is as neglected by the health care system

• Patients must turn to a broad range of practitioners largely exempt from medical standards

Slide courtesy of Steve Martin MD
Patients Face Formidable Barriers to Receiving Addiction Treatment Due To:

- A misunderstanding of the disease
- Negative public attitudes and behavior toward those with the disease
- Privacy concerns
- Insufficient insurance coverage for treatment
- Lack of information on how to get help
- Limited availability of services including a lack of addiction physician specialists
- Insufficient social support
- Negative perceptions of the treatment process
- Legal barriers
MAT in Primary Care in Maine

Sources of data:
• Maine Prescription Drug Monitoring Program (PMP)
• Federal SAMHSA (Substance Abuse & Mental Health Svcs Administration) websites
• Individual meetings & calls w/ MAT prescribers

Maine primary care “universe”
• Approx. 500 primary care practice sites
• Approx. 2000 primary care physicians
• Approx. 1400 primary care NPs & PAs
MAT in Primary Care in Maine

- Per Maine PMP:
  - 344 licensed buprenorphine tx prescribing physicians
  - **214 physicians actually prescribed tx in 2015**

- Approx. 45% Addiction Specialists; 50% Family Med, 5% Internal Medicine

- Significant differences in prescribing by county:
  - Highest rates: Knox, Lincoln, Washington
  - Lowest: Aroostook, Franklin, Piscataquis

- MAT benefit accessed by pts w/ range of payers:
  - Commercial payers 48% -- Self-pay 12%
  - Medicaid 34% -- Medicare 6%
MAT in Primary Care in Maine

• Per SAMHSA “Buprenorphine Physician Locator”: 205 prescribing Maine physicians, NPs, & PAs
  – Mix of primary care & addiction specialists
  – Several ‘cash only’ practices

• Per addnl SAMHSA website: 189 prescribing Maine physicians
  – 172 certified for 30 patients
  – 17 certified for 100 patients

(vs. 214 physicians who actually prescribed bup in 2015, per PMP)

* Note: physicians are not required to publicly post their name/info on SAMHSA site
MAT in Primary Care in Maine

Info from interviews with MAT prescribers & additional queries:

• Est. ~40 - 50 primary care practice sites currently offering MAT

• Often limited to 1-2 prescribers/site

• Some associated with addiction tx center with referral relationship; others identify and tx patients independently

• Several are “cash practices”

• Many Maine communities have no access to MAT in primary care
MAT in Primary Care in Maine – Ex’s

- **Aroostook/Penobscot Counties**
  - HAN Lincoln, Millinocket
  - Aroostook Wellness, D Conner MD
  - Pines Health Cntr, St. John Valley

- **Bangor area**
  - EMMC Family Med
  - PCHC Bangor
  - Gary Ross DO (cash)

- **Downeast**
  - Eastport Health Center
  - Regional Med Cntr Lubec
  - MDI practices (CHC, Cooper Gilmore)
  - Island Health Center (C. Zelnick)

- **Mid Coast area**
  - Pen Bay Med Cntr
  - PCHC Seaport Hlth Cntr
  - Wiscasset Family Medicine

- **VA System (several)**

- **Augusta area**
  - MEGenl/ ME Dartmouth FP
  - Sheepscot Valley Hlth Cntr
  - Winthrop Family Medicine
  - Be Well My Friend (cash?)
  - ME Recovery Cntr/ D Jorgensen DO, R Fein DO (cash)

- **Lewiston area**
  - Mollison Way/St Marys
  - Wilson Stream FP

- **Portland area**
  - Greater Portland Health Care
  - MMC Family Med Center
  - MMP Scarborough
  - MMP Westbrook
  - Martins Point (Ptld, Falmouth)
  - George Gardner DO (cash)
  - John Stedman DO (cash)
  - Steep Falls Family Practice
MAT in Primary Care in Maine

• Varied MAT models:
  – Primary care sites providing maintenance MAT, with relationship to addiction treatment centers for initial induction, referral, & specialty back-up
  – Primary care practices doing both induction & maintenance
  – Cash practices offering induction & maintenance

• Varied approaches to induction

• Varied models for, frequency of SUD/OUD counseling (group, individual; significant to minimal)
MAT in Primary Care in Maine

- Variable practice ownership & oversight
  - Hospital/health system
  - FQHCs
  - Independent practices

- Variable approach to monitoring patients for relapse and/or diversion – i.e.
  - Pill counts
  - Urine drug screening
  - Apparently variable compliance w/ Chapter 21 reg’s

- Variable approach to patient relapse
  - “3 strikes” vs. referral to higher level of addiction tx
MAT in Primary Care in Maine

Concerns re: “cash practices”

• Appear to have high MAT patient volume (100+?)
• Counseling models not clear
• No consistent relationships to specialty addiction treatment center
• High potential for diversion
• No apparent oversight of prescribers by state/DEA
SUD/MAT in Primary Care Training Prgms

• Medical schools
  – UNECOM: Yes - opioid curriculum
  – MMC-Tufts: Yes – MA opioid curriculum

• Primary care residency programs
  – EMMC Family Medicine: Yes
  – MMC Internal Medicine: ?
  – MMC Ob-Gyn: No
  – MMC Family Medicine: Yes
  – CMMC Family Medicine: Yes
  – ME-Dartmouth Family Medicine: Yes
Barriers to MAT in Primary Care

- Negative attitudes towards individuals with SUD/OUD
- Low levels of motivation to treat SUD/OUD
- Limitations in prescriber knowledge, skills & experience
- Lack of access to psychosocial supports (individual counseling, community-based supports)
- Limited resources for initiation of MAT programs
- Lack of coordination of MAT with broader health care community

1: AHRQ RFA-HS-16-001: as identified at 2015 Buprenorphine Summit. SAMHSA-NIDA 2014
Barriers to MAT in Primary Care

• Lack of institutional support
• Lack of MH and psychosocial support
• Time constraints
• Lack of specialty backup
• Lack of confidence in ability to manage opioid addiction
• Resistance from practice partners
Successful Models – Other States

Vermont: “Hub & Spoke” model

• Goal: integrate treatment services for substance abuse issues into medical home through team approach
• Hubs = specialty addiction treatment sites, responsible for coordinating care for indiv’s with addiction
• Spokes = ongoing care system between prescribing physician and collaborating health & addictions professionals (Blueprint PCMH and/or FQHCs)
• Enhanced payment through Medicaid Health Homes

https://www.mainequalitycounts.org/articles/142-1603/caring-for-me-ag-hub-and-spoke-model/1
Hub & Spoke: Interdisciplinary Model of Care

- **Hubs:** Addiction specialty sites (SAMSHA-recognized Outpatient Treatment Centers)
- **Spokes:**
  - Primary care providers, OB-Gyns, Psychiatrists
  - Community Health Teams
    - RN: insurance authorizations, urine drug testing, med refills
    - Behavioral Health Provider: addiction counseling, social service support
VT Care Alliance for Opioid Addiction: Treatment Center Service Regions
Vermont: Hub & Spoke Model
Maine “Hub & Spoke” MAT Models

- No formal/statewide approach
- Challenging to get baseline data
- Several emerging local models
- Variations in “hub” & “spoke” concept
- 10 MeHAF “Addiction Care” grantees
MaineCare Opioid Health Homes

• New MaineCare program offering bundled (capitated) payment for OUD treatment
• Aims to have behavioral health or primary care org’s deliver team-based svc’s:
  – Substance abuse counseling
  – Care coordination
  – Medication-assisted Treatment (MAT)
  – Peer support
  – Medical consultation
• To date, 4 Opioid Health Homes approved
New & Emerging Models for MAT

• **Groups** (formerly, Recover Together)
  – 5 sites in ME
  – Cash ($65/wk) or insurance payments
    • Includes visits, drug screens
    • Medication costs extra (est’d at $45-50/wk)

• HIT-enabled visits, counseling
  – Online MAT visits – e.g. Mark Publicker MD
  – **Pear Therapeutics** – mobile app to support MAT
Re-Examining
Fundamental Questions:

1. Do you believe addiction is a disease?
2. Should addiction be treated?
3. Can addiction be treated effectively?
4. Do clinicians have a moral obligation to treat addiction?
Our Hurricane Harvey Opportunity?
What If?...

• Each primary care practice in Maine supported at least 2 MAT prescribers?

• Maine would see tx capacity increase from...
  – ~50 to 500 practices offering MAT treatment
  – ~200 to 1000 providers offering MAT treatment
  – ~250 to 5000 available spots for patients to receive effective addiction treatment (at 50 pts/provider)
What Will It Take?

• Concerted efforts to reduce stigma, shame, & cultural biases surrounding addiction & addiction treatment
• Efforts to reduce barriers / provide coverage for uninsured
• Engagement of communities, health system & provider leadership re: need for more treatment
• Expectation that health professional schools & residency programs teach MAT training, team-based approaches
• Education, specialty, and social svcs/recover support for primary care providers to offer MAT
What Can You Do?

• Examine your own personal biases & beliefs
• Educate yourself – and your friends!
• Ask questions...
  – Does this practice/site offer MAT?
  – Does this residency/training program train clinicians to offer MAT?
  – Do other clinicians in this community offer MAT?
  – If not, why not?
What Can You Do?

Watch your language!

<table>
<thead>
<tr>
<th>Instead of...</th>
<th>Try:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addict</td>
<td>Person with addiction</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Substance use disorder</td>
</tr>
<tr>
<td>Urine is clean/dirty</td>
<td>Urine screened positive for...</td>
</tr>
<tr>
<td>Person/pt is clean</td>
<td>Person/pt in recovery</td>
</tr>
</tbody>
</table>

Caring for ME

- Proactive, positive leadership response to Maine’s opioid crisis and 2016 legislation mandating prescribing limits
- Partnership of MMA & QC
- Promote shared communication, education & support
- Help providers maintain compassionate approach to chronic pain management, addiction diagnosis & treatment
- [www.mainequalitycounts.org/caringforme](http://www.mainequalitycounts.org/caringforme)
The Power of A Story...

www.bit.ly/MaineMAT (2 mins)

https://www.youtube.com/watch?v=3pT_BJtsraA (8.5 mins)
Our Call to Action

David McCarthy - 29 yo  Coleen Singer – 32 yo  David Zysk – 33 yo
Contact Info / Questions

Lisa Letourneau MD, MPH
  • Letourneau.lisa@gmail.com

Caring for ME
www.mainequalitycounts.org/caringforme

Maine Quality Counts
Amy Belisle, MD, Medical Director
  ABelisle@mainequalitycounts.org

MAT in Primary Care
https://www.mainequalitycounts.org/page/2-1539/mat-for-primary-care-teams

CDC Guidelines Chronic Pain & Opioids:
http://www.cdc.gov/drugoverdose/prescribing/guideline.html
MAT Panel 101 Members

- Lisa Letourneau, MD, MPH - Moderator
- Noah Nesin, MD – Vice President of Medical Affairs, Penobscot Community Health Care
- Alane O’Connor, DNP – Family Medicine Practitioner, MaineGeneral Medical Center - Thayer Center for Health - Maine Dartmouth Family Practice
- Mary-Beth Leone-Thomas, LCSW - Staff Social Worker and Consultant, Seaport Community Health Center
Medication Assisted Recovery in Primary Care

University of New England
October 28, 2017

Noah Nesin, MD, FAAFP
Vice President of Medical Affairs
PCHC
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Disclosures

Nothing to see here...
What Does It Take?

• Advocacy and Education
• Patience and Persistence
• Mentors and Role Models
Advocacy and Education

- Practice leaders
- Public officials
- Police departments
- Policy makers
- Providers
- Primary care teams
- Public
Education

- American College of Physicians
- University of New England
- University of Maine
- Maine Health
- American Society of Health Systems Pharmacists
- Maine Society of Health Systems Pharmacists
- American Pharmacy Association / HRSA Office of Pharmacy Affairs
- Maine Pharmacy Association
- Maine Medical Association
- Maine Osteopathic Association
- Brewer Police Department
- Bangor Police Department
- Penobscot County Sheriff Department
- Daniel Hanley Center for Health Leadership
- Bangor Regional Leadership Institute
- Maine Health Allies
- Apexus 340B University
- Maine Development Foundation
- MEHAF
- MPCA
- Maine Quality Counts
Education

- **Husson School of Pharmacy**
- EMMC Center for Family Medicine
- St. Joseph Healthcare
- Health Access Network
- Hometown Healthcare
- Mayo Regional Hospital
- Bucksport Regional Health Center
- CMMC Family Practice Residency
- AHRQ
- National Integration Academy Council
- Maine Nurse Practitioner Association
- Maine Hospice Council
- DHHS
- Maine Legislature (Education Day)
- Lunder Dineen Health Education Alliance
- Greater Portland Health
- Husson Family Medicine
Patience and Persistence

- There will be bumps in the road
- It will take longer than expected
- Usual change dynamics
- Some unique aspects of this piece of primary care
- Resisters look for “told you so” moments
- Mistakes happen
- Stigma, shame and bias abate gradually

![Savage Chickens](image)
Mentors and Role Models
Bangor CHLB and BACSWG

- Acadia Hospital
- Bucksport Regional Health Center
- Center for Family Medicine
- CHCS
- EAAA
- EMMC
- Health Access Network
- Mayo Regional Hospital
- PCHC
- PVH
- St. Joseph Healthcare
- Wellspring

“We like to bring together people from radically different fields and wait for the friction to produce heat, light and magic. Sometimes it takes a while.”
BACSWG

Standards for:
• Chronic opioid prescriptions
• Chronic benzo prescriptions
• Chronic stimulant prescriptions
• ED prescribing

Working on standards for:
• Specialty and surgical prescribing
• Dental and oral surgeon prescribing
• Pediatric prescribing

Addressed:
• Dental prescribing
• Expanded access for MAR
• Naloxone distribution
• Social Detox Center
PCHC Particulars

**Controlled Substance Stewardship**
- Education
- Prevention
- Awareness of addiction
- Interdisciplinary approach
- Sustained vigilance

**CHAMP**
- Addresses bias and stigma internally and externally
- Addresses earliest trauma
- Maybe prevents “turning on” addiction genes?
Noah’s Unofficial and Likely Derivative Chronic Pain and Suffering Principle (NULDCPSP)

Role of Emotion in the Intensity of Chronic Pain vs. Time

- Emotional/Psychosocial Factors
- Suffering
- Insight

Graph showing the relationship between the role of emotion in the intensity of chronic pain and time, with emotional/psychosocial factors, suffering, and insight indicated.
Trauma Informed Care

Early Death
Disease, Disability, and Social Problems
Adoption of Health-risk Behaviors
Social, Emotional, and Cognitive Impairment
Disrupted Neurodevelopment
Adverse Childhood Experiences

Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan
1 Apple every 8 hours will keep 3 Doctors away.
Opioid Use Disorders and Medication Assisted Treatment (MAT) in Maine

Alane O’Connor, DNP

Maine Dartmouth Family Medicine Residency/ MaineGeneral Medical Center
Screening for substance use disorders

• Screening tools by substance type, age of patient, how tool is administered.
• It is hard to talk about substance use... this is a good place to start.
Opioid use disorder

• Pattern of opioid use that causes impairment or distress:
  – Tolerance
  – Withdrawal
  – Cravings
  – Interfering with personal life
  – Persistent desire to cut back
  – Time spent trying to obtain drugs or recover from the effect.

• Check list https://www.buppractice.com/node/19556
Red flags for opioid use disorder

- Misuse of medications (track marks, intranasal use).
- Purchasing off the street.
- Legal troubles.
- Overdose.
- Drug screens with multiple substances.
I’ve identified an OUD. Now what?

• Don’t panic. It’s not a medical emergency.
• Does the patient agree with your assessment?
• Does the patient want treatment?
  – Encourage motivation to change.
  – Narcan.
Medication assisted treatment

• Medication assisted treatment (MAT): medication + counseling and behavioral therapies.

• Behavioral health care is essential.
  – Referral to counseling.
  – Encourage 12-step meetings.
  – LOCA: IOP?
Medication assisted treatment

- **Buprenorphine**
  - Outpatient, requires x waiver.
- **Methadone**
  - Federally licensed clinics only
- **Naltrexone**
  - Must be opioid free.
Polysubstance use

• Marijuana.
  – “I have my green card.”

• Stimulants, benzodiazepines.
  – Limit exposure, increase counseling.
  – How about an SSRI?

• Alcohol.
  – Complicated and likely very prevalent.

• Tobacco
  – Don’t forget to address! Can tackle both addictions at the same time.
Co-occurring mental health disorders

• Addiction will not be stable if mental health not stable.
• Co-occurring disorders extremely common.
• Aggressively manage with psych meds as needed.
  – Bupropion good choice (no seizure history, “swellbutrin.”)
  – Duloxetine good choice. Avoid venlafaxine.
  – Sertraline, escitalopram maybe better than other SSRIs.
Co-occurring mental health disorders

- PRN meds for anxiety okay but want to avoid drug seeking behavior.
  - Clonidine, hydroxyzine, buspar.
  - No benzos.

- Manage sleep disorders.
  - Trazodone, clonidine, mirtazapine good options.
  - Avoid sedative hypnotics.
  - Ask about alcohol.
Social issues

- Domestic violence.
- Where are the kids?
Questions
MAT Panel 101 Members

- Lisa Letourneau, MD, MPH - Moderator
- Noah Nesin, MD – Vice President of Medical Affairs, Penobscot Community Health Care
- Alane O’Connor, DNP – Family Medicine Practitioner, MaineGeneral Medical Center - Thayer Center for Health - Maine Dartmouth Family Practice
- Mary-Beth Leone-Thomas, LCSW - Staff Social Worker and Consultant, Seaport Community Health Center