

The Role of Clinicians in Addressing the Opioid Overdose Epidemic

Clinician Outreach and
Communication Activity (COCA)
Call
September 24, 2015

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Objectives

At the conclusion of this session, the participant will be able to:

- ❑ **Review the epidemiology of opioid-related morbidity and mortality**
- ❑ **Describe the challenges of managing patients with pain conditions as well as patients who have opioid use disorders**
- ❑ **Discuss the FDA-approved treatments for opioid use disorders**
- ❑ **Discuss the steps that can be taken to improve opioid analgesic prescription for the treatment of pain**
- ❑ **Identify the steps that can be taken to incorporate opioid use disorder treatment into clinical practice**

TODAY'S PRESENTER



Christopher M. Jones, PharmD, MPH

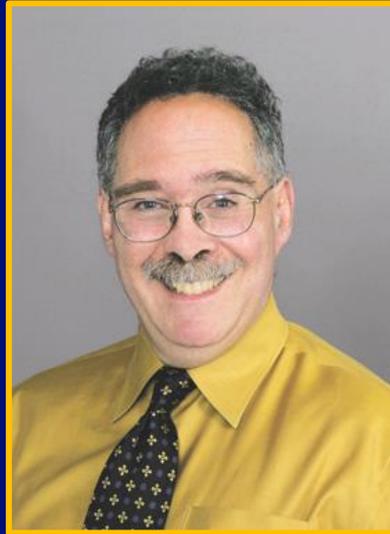
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TODAY'S PRESENTER



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The Clinician's Role in Addressing the Opioid Overdose Epidemic

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Office of the Assistant Secretary for Planning and Evaluation

Learning Objectives

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Overview

- **Epidemiology**

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- **Pain management**

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- **Opioid use disorder treatment**

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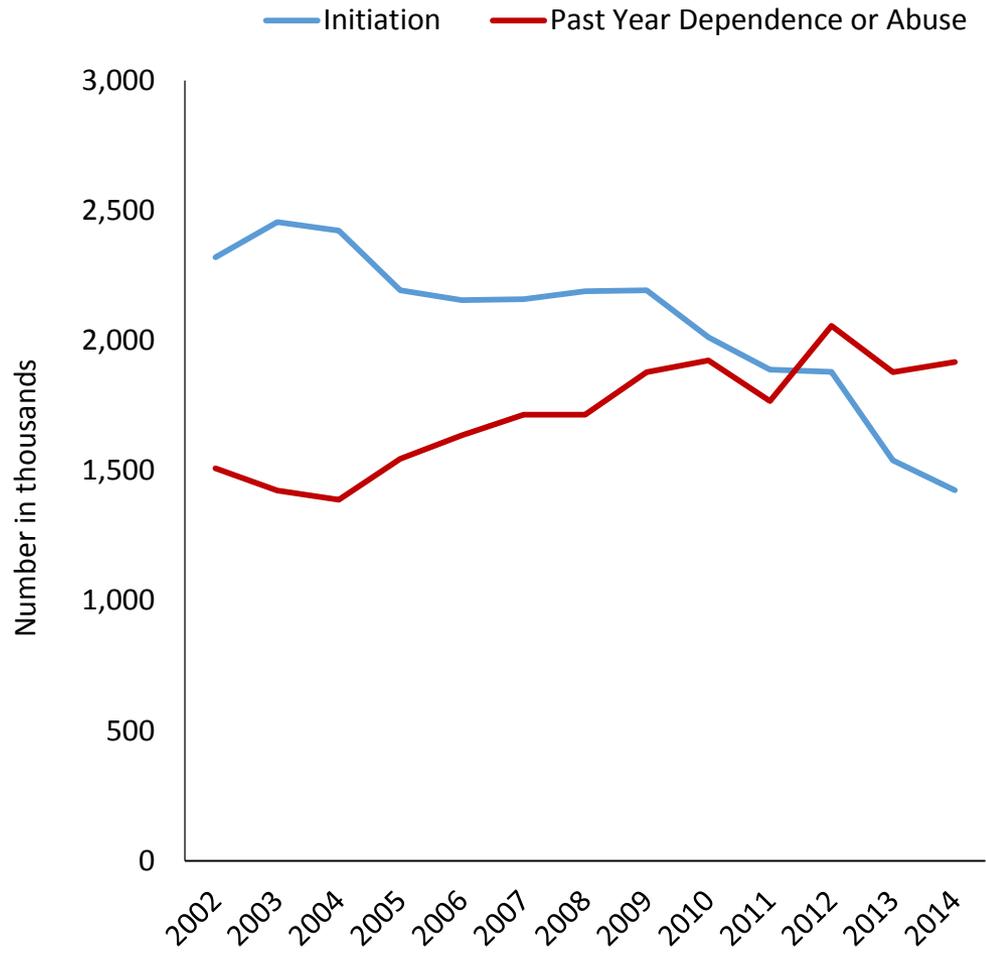
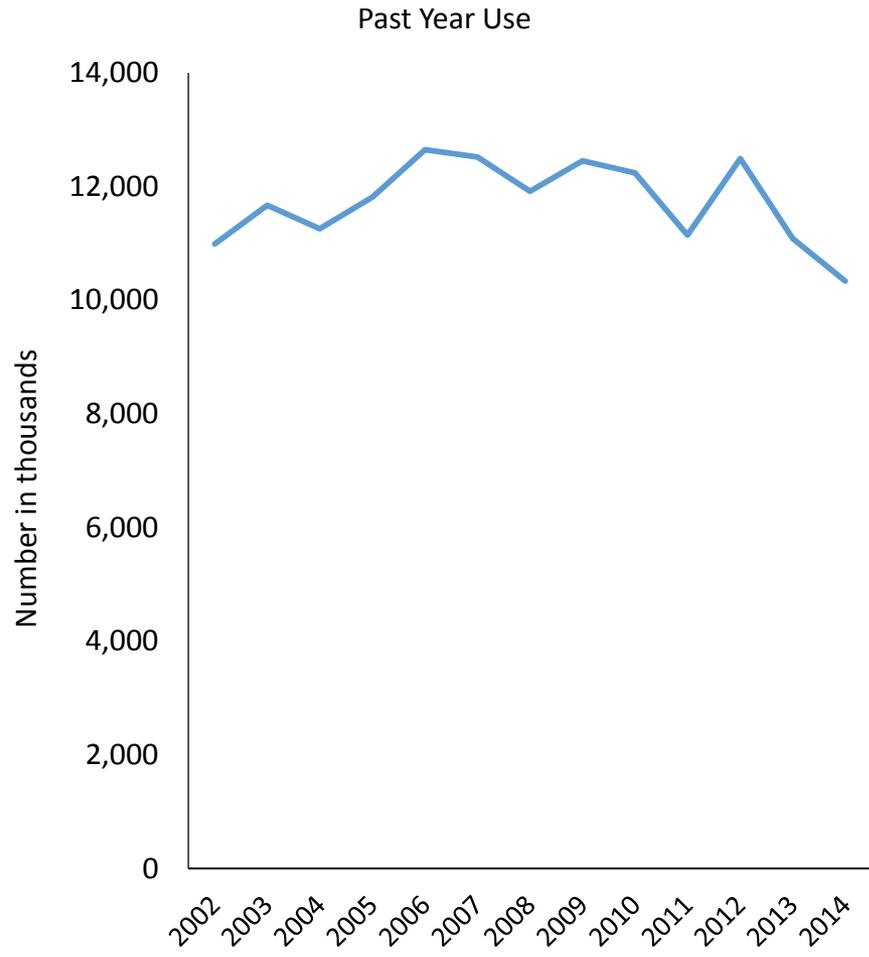
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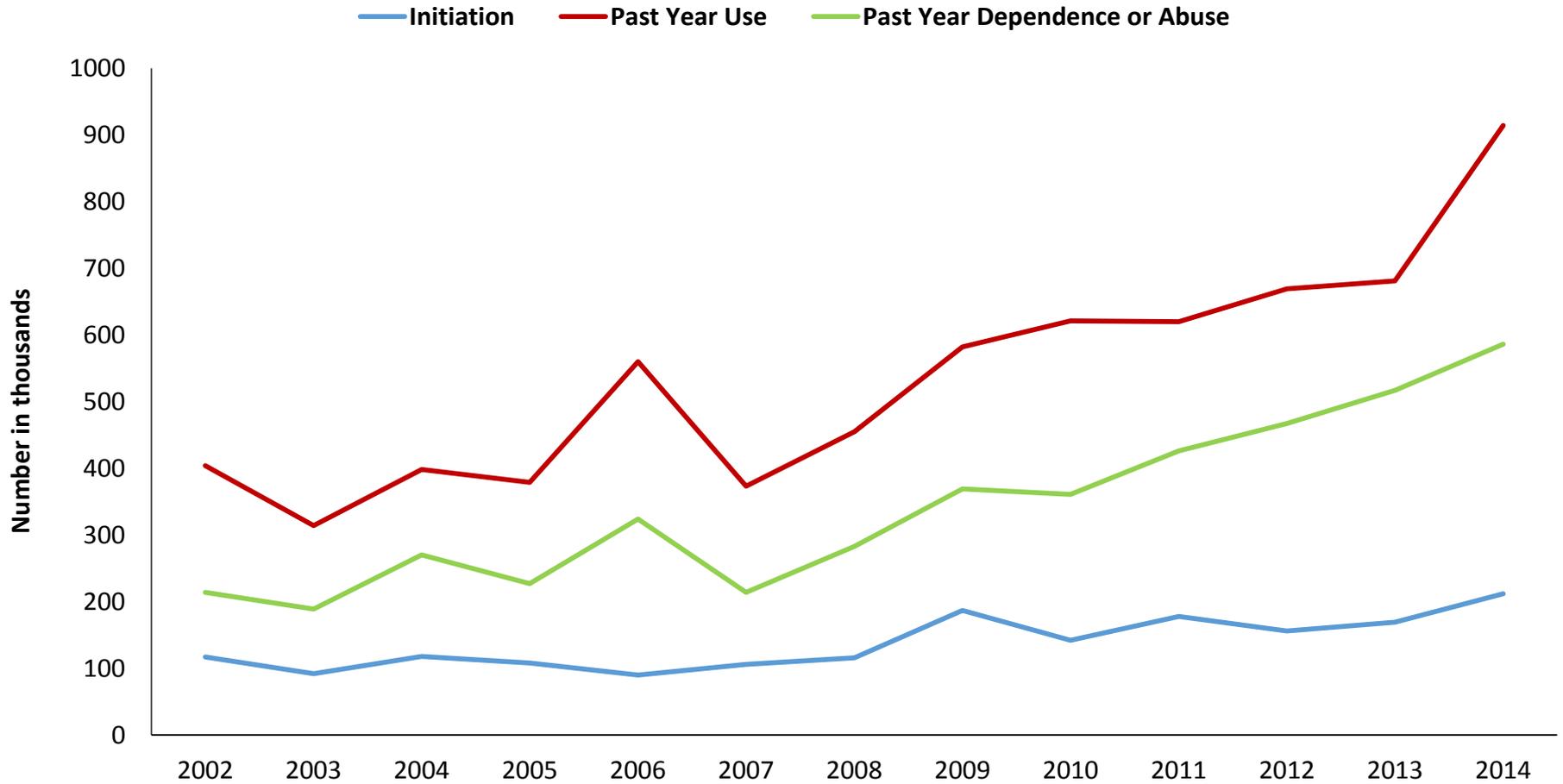
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Rx opioid trends

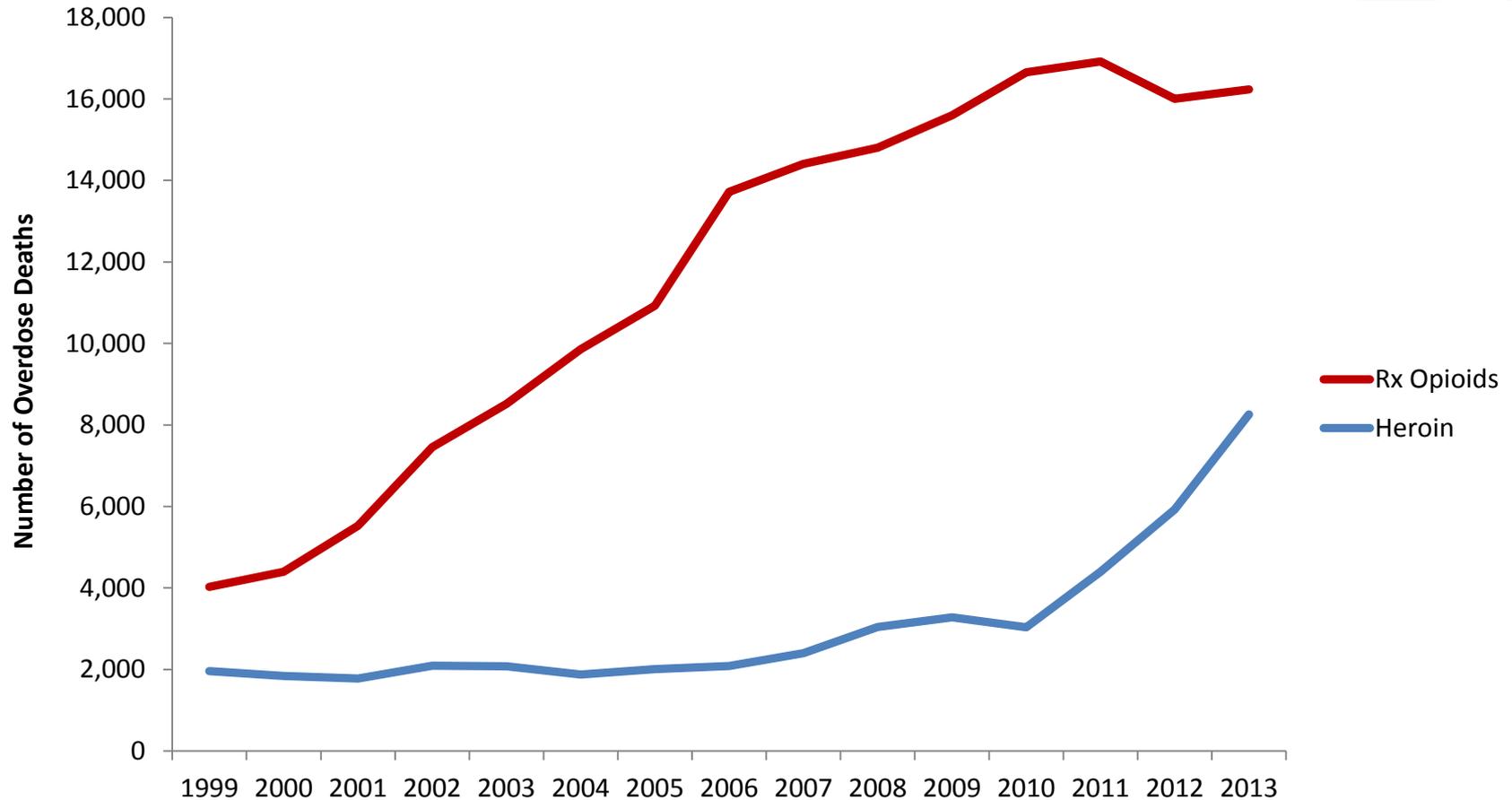


Source: SAMHSA National Survey on Drug Use and Health, 2002-2014

Heroin trends



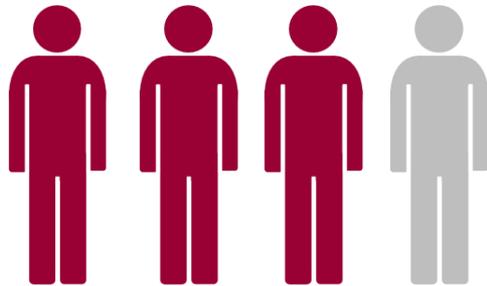
Overdose Deaths Involving Rx Opioids and Heroin United States, 1999-2013



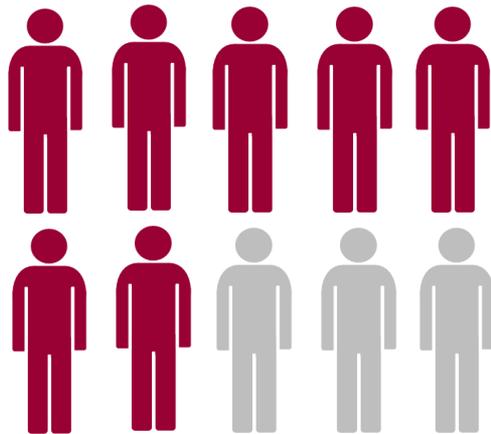
Changing demographics of heroin use

	2002-2004*	2011-2013*	% CHANGE
SEX			
Male	2.4	3.6	50%
Female	0.8	1.6	100%
AGE, YEARS			
12-17	1.8	1.6	--
18-25	3.5	7.3	109%
26 or older	1.2	1.9	58%
RACE/ETHNICITY			
Non-Hispanic white	1.4	3	114%
Other	2	1.7	--
ANNUAL HOUSEHOLD INCOME			
Less than \$20,000	3.4	5.5	62%
\$20,000–\$49,999	1.3	2.3	77%
\$50,000 or more	1	1.6	60%
HEALTH INSURANCE COVERAGE			
None	4.2	6.7	60%
Medicaid	4.3	4.7	--
Private or other	0.8	1.3	63%

Nonmedical use of Rx opioids significant risk factor for heroin use

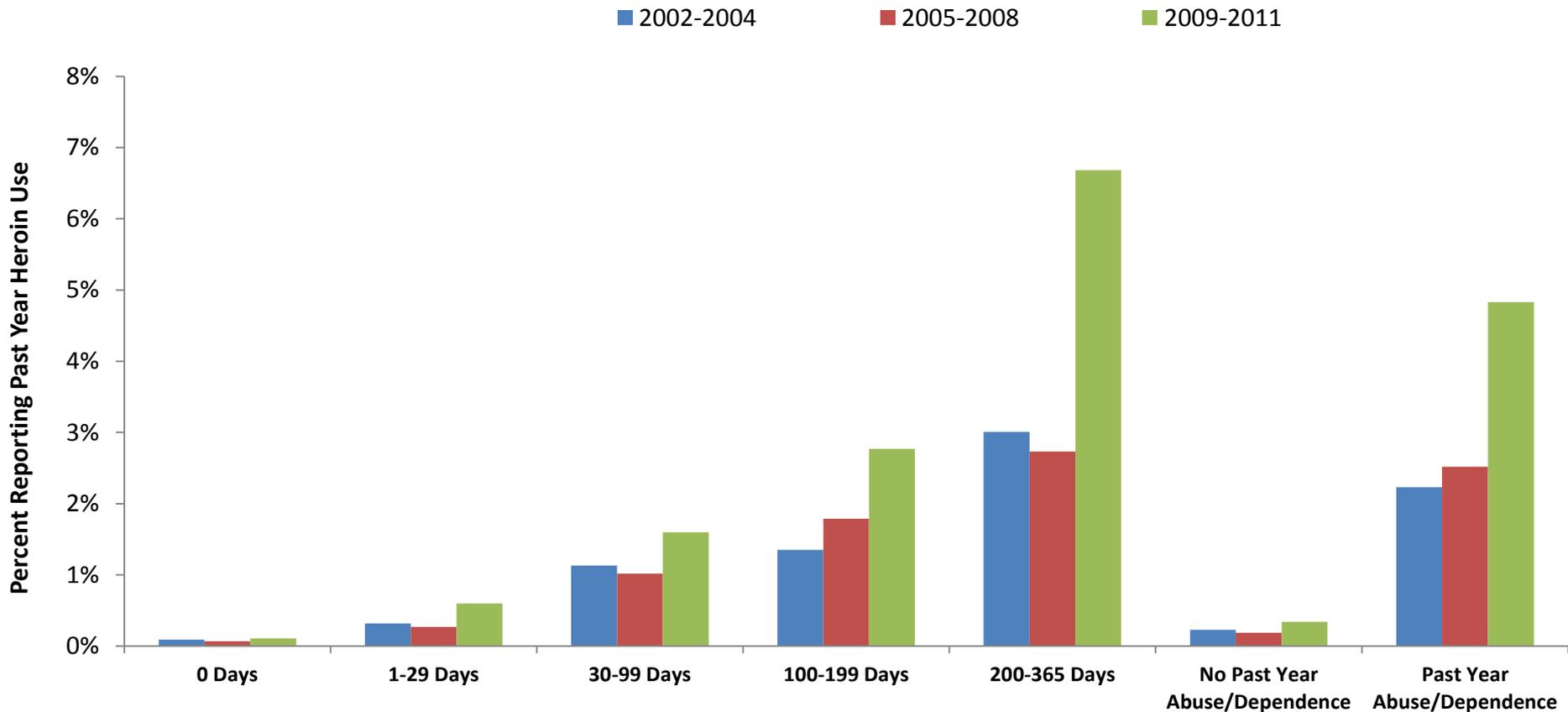


3 out of 4 people
who used heroin in the
past year misused
opioids first

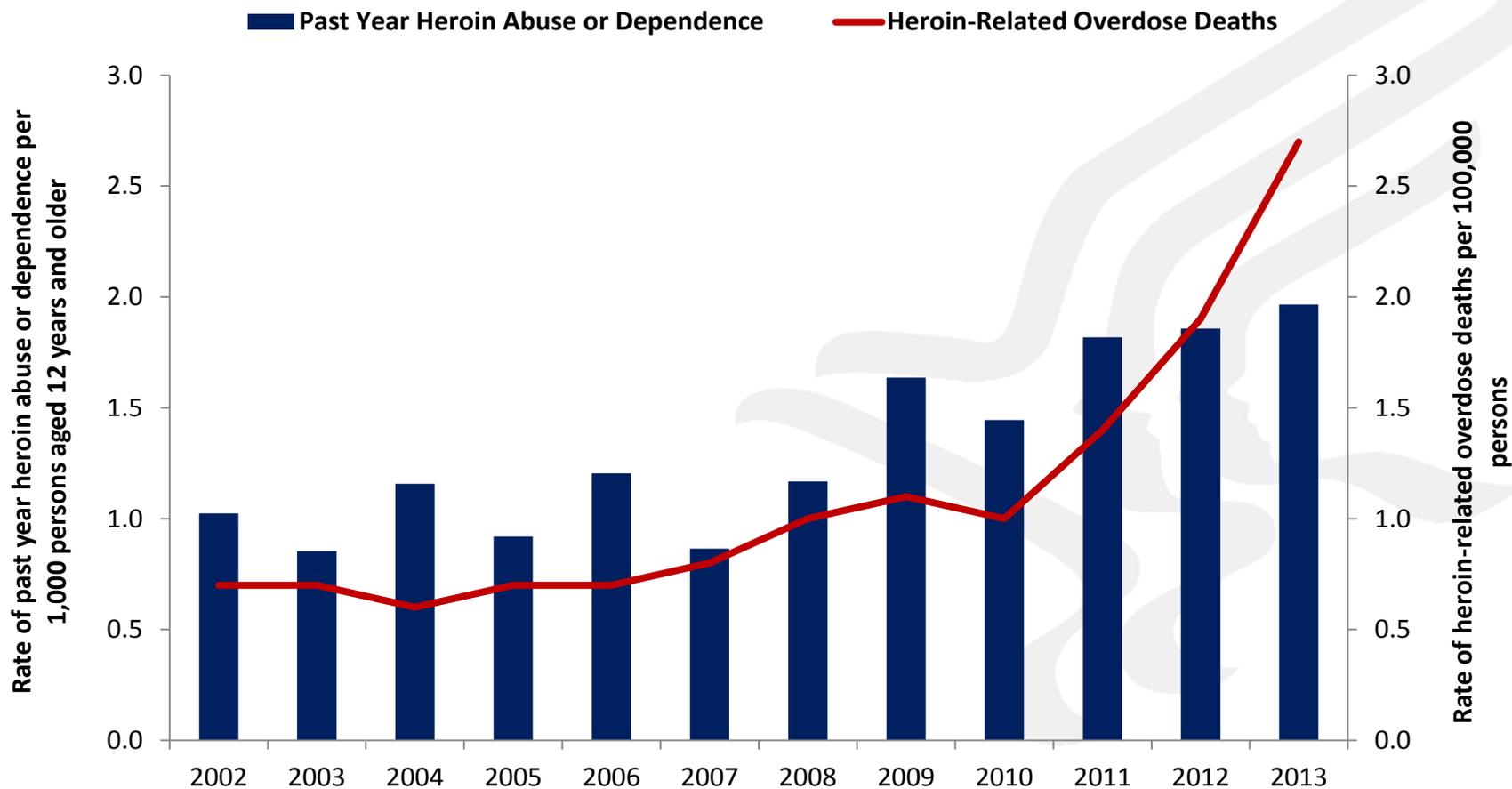


7 out of 10 people
who used heroin in the
past year also misused
opioids in the past year

Frequent nonmedical users of Rx opioids and those with abuse/dependence most likely to initiate heroin



Heroin Abuse or Dependence and Overdose Deaths Tightly Correlated



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Other Substance Abuse or Dependence Elevates Risk for Heroin Abuse or Dependence

People with abuse or dependence on:

ALCOHOL

are

2x

MARIJUANA

are

3x

COCAINE

are

15x

Rx OPIOID PAINKILLERS

are

40x

More likely to have heroin abuse or dependence



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Essential Elements to Stopping the Epidemic



PREVENT People From Starting Heroin

Reduce prescription opioid painkiller abuse.

Improve opioid painkiller prescribing practices and identify high-risk individuals early.



REDUCE Heroin Addiction

Ensure access to Medication-Assisted Treatment (MAT).

Treat people addicted to heroin or prescription opioid painkillers with MAT which combines the use of medications (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.



REVERSE Heroin Overdose

Expand the use of naloxone.

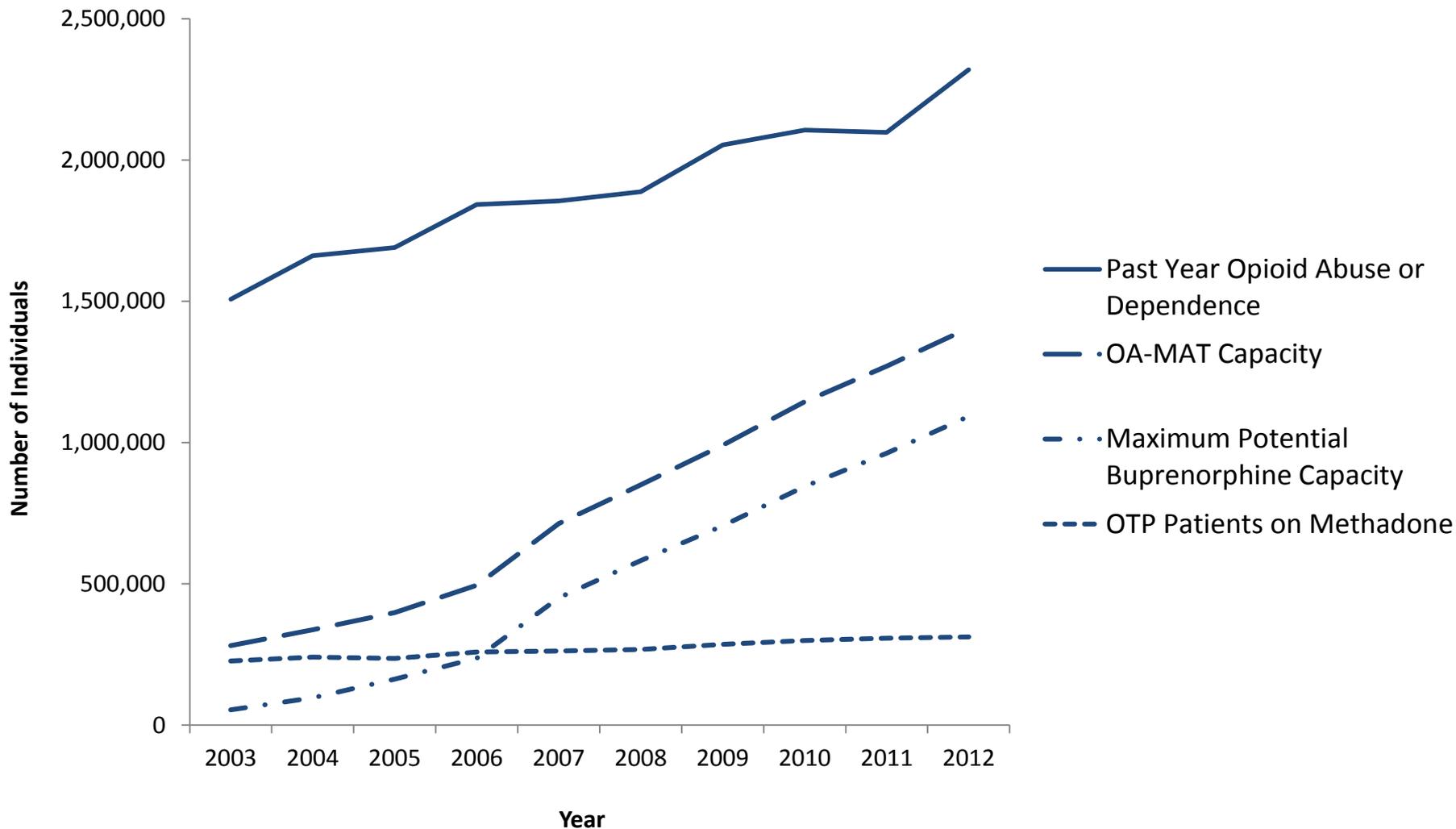
Use naloxone, a life-saving drug that can reverse the effects of an opioid overdose when administered in time.



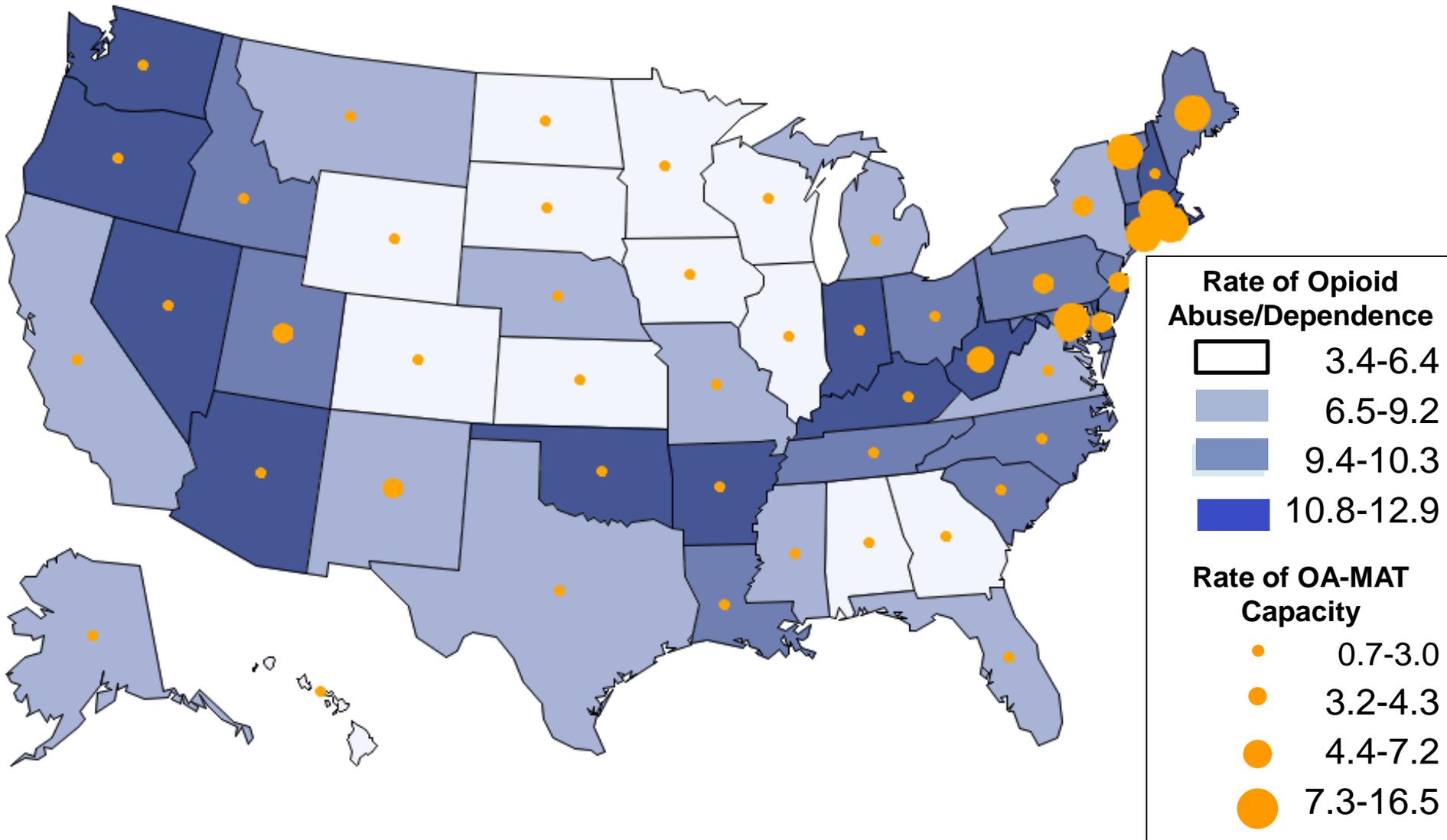
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Treatment need for opioid abuse or dependence exceeds capacity for opioid agonist medication assisted treatment (OA-MAT) in the US



Rate of Past Year Opioid Abuse or Dependence and Rate of OA-MAT Capacity (rate per 1,000 persons aged 12 years and older)



Thank You

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Reversing the opioid epidemic and improving outcomes for your pain patients

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The worst man-made epidemic in modern medical history

- Over 200,000 deaths
- Many more hundreds of thousands of overdose admissions
- Millions addicted and/or dependent
 - Degenhardt et al Lancet Psychiatry 2015; 2: 314-22; POINT prospective cohort: DSM-5 opioid use disorder: **29.4%**
- **Spillover effect to to SSDI***

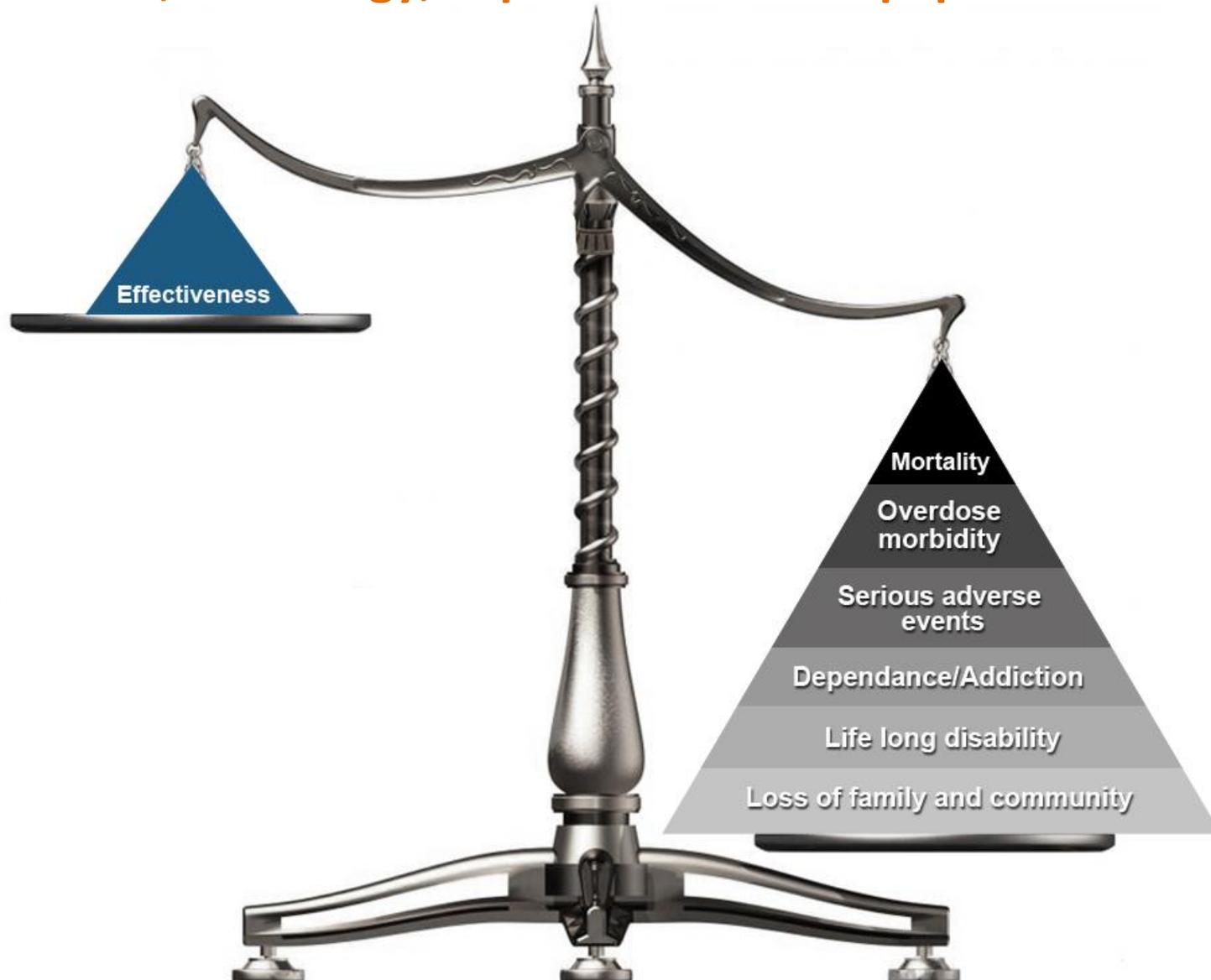
*Franklin et al, Am J Ind Med 2015; 58: 245-51

Evidence of effectiveness of COAT

The Agency for Healthcare Research and Quality's (AHRQ) recent draft report, "The Effectiveness and Risks of Long-term Opioid Treatment of Chronic Pain," which focused on studies of effectiveness measured at > 1 year of COAT use, found **insufficient data on long term effectiveness to reach any conclusion, and "evidence supports a dose-dependent risk for serious harms"**. (AHRQ 2014; Chou et al, Annals Int Med, 13 Jan 2015).

Risk/Benefit of Opioids for Chronic Non-Cancer Pain

-Franklin; Neurology; Sept 2014-Position paper of the AAN-



**Risk/Benefit of Opioids for Chronic Non-Cancer Pain
-Franklin; Neurology; Sept 2014; AAN Position paper-**

Opioids should not be used routinely for the treatment of routine musculoskeletal conditions, headaches or fibromyalgia*

*WA DLI opioid guidelines, 2013 <http://1.usa.gov/1nYlarL>

WHY NOT PRESCRIBE FOR CHRONIC LOW BACK PAIN?

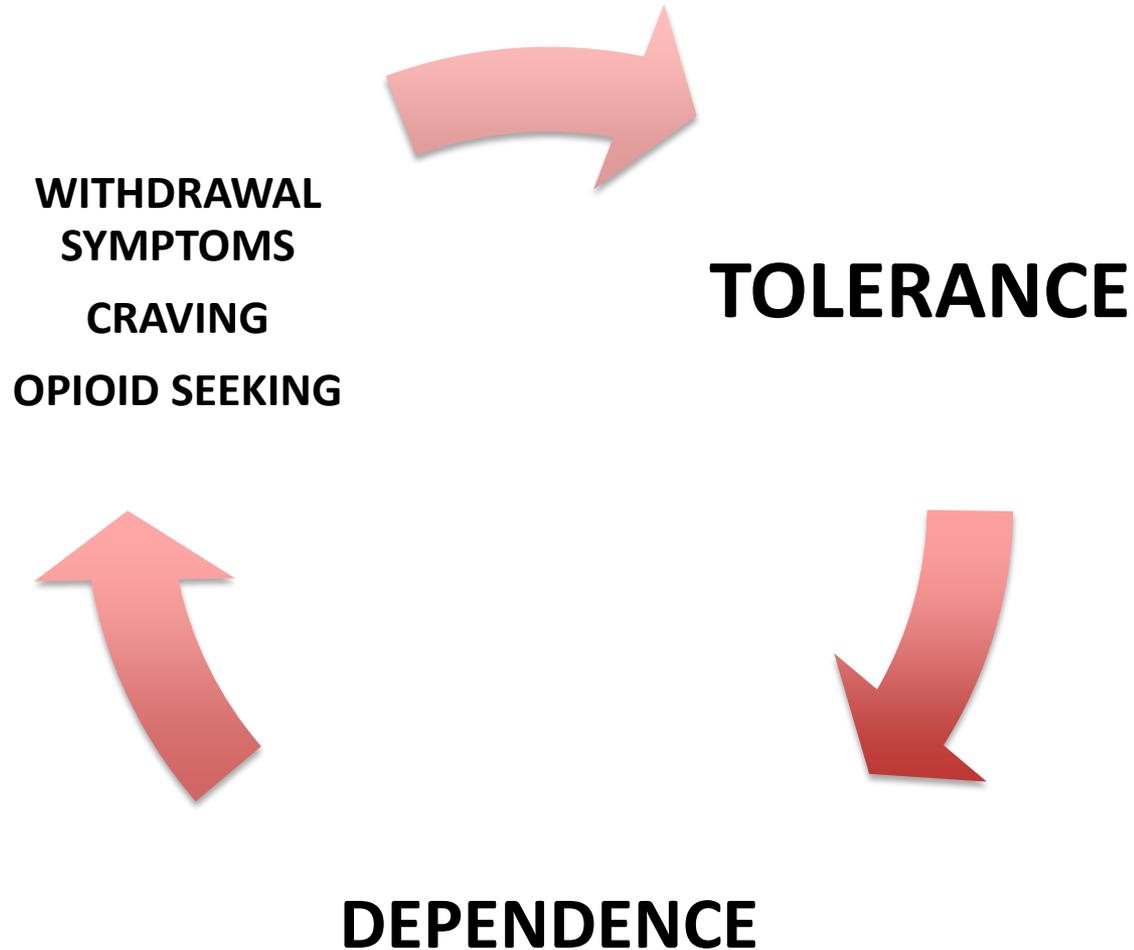
- Alternative treatments, particularly programs that take a psycho-physical approach, have stronger evidence base¹
- Opioids generally are deactivating and not activating
- Reduced prescribing for non-specific back pain would significantly reduce overall prescribing and availability, and thus safety – public health benefit
- Eliminating prescribing for common indications that have failed would be a step towards identifying cases that do derive benefit

Hill et al Lancet 2011;378:1560-71; slide courtesy Jane Ballantyne, MD

Early opioids and disability in WA WC. Spine 2008; 33: 199-204

- Population-based, prospective cohort
- N=1843 workers with acute low back injury and at least 4 days lost time
- Baseline interview within 18 days(median)
- 14% on disability at one year
- **Receipt of opioids for > 7 days, at least 2 Rxs, or > 150 mg MED doubled risk of 1 year disability, after adjustment for pain, function, injury severity**

Tolerance/dependence inevitable consequence of continued use



Enduring adaptation produced by established behaviors

Addiction criteria may be different for pain patients on chronic opioids

For the illicit drug user:

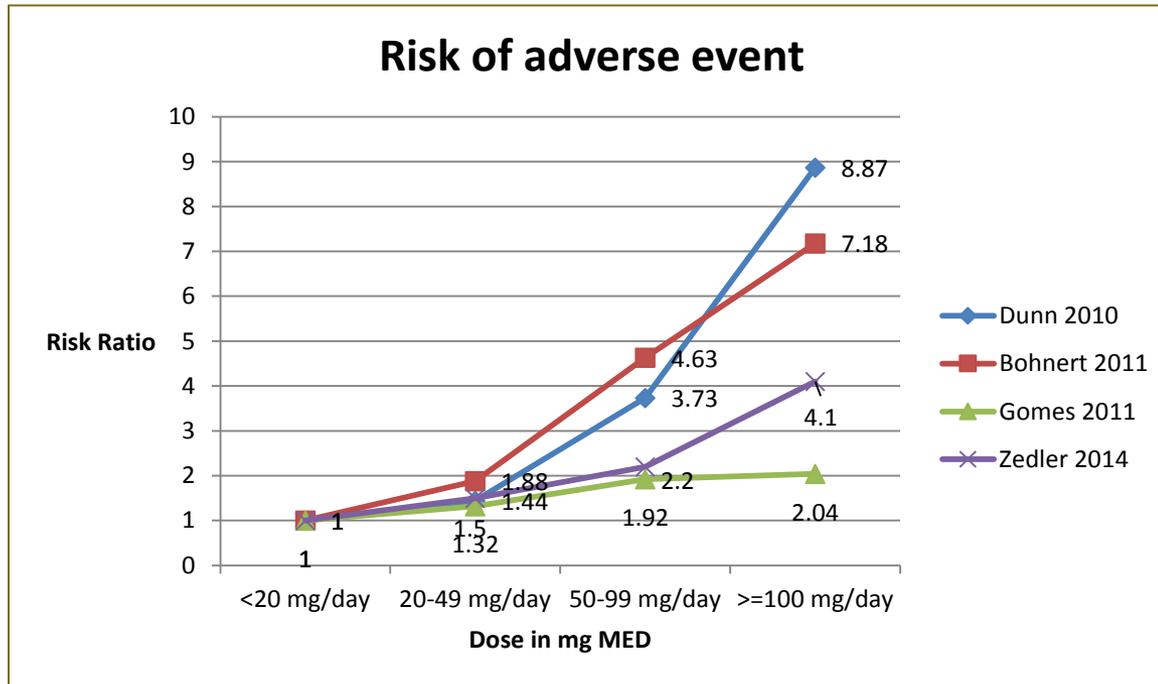
- Procurement behaviors

For the pain patient – much more complex:

- Continuous opioid therapy may prevent opioid seeking
- Memory of pain, pain relief and possibly also euphoria
- Even if the opioid seeking appears as seeking pain relief, it becomes an adaptation that is difficult to reverse
- It is hard to distinguish between drug seeking and relief seeking

Ballantyne JC, Stannard C. New addiction criteria: Diagnostic challenges persist in treating pain with opioids. IASP: Pain clinical updates, Dec 2013; 21: 1-7; URL: http://iasp.files.cms-plus.com/FileDownloads/PCU_21-5_web.pdf

Responding to the EVIDENCE: Morphine Equivalent Dose RELATED RISK



- Risk of adverse ± overdose event increases at >50 mg MED/day
- Risk increases greatly at ≥100 MED/day

2007: WA State AMDG initially recommends 120 MED threshold dose

2012: CT work comp: 90 mg/day MED

2013: OH State Medical Board: 80 mg/day MED

2013: Am College Occ. & Enviro. Med: 50 mg/day MED

2014: CA work comp: 80–120 mg/day MED

Opioid Dosing Policies Since 2007

- 2007: WA AMDG recommended consultation at **120** mg/day MED
- 2010: WA ESHB 2876 directed DOH Boards and Commissions to establish dosing guidance and best practices
- 2012: CT workers comp recommended a threshold at **90** mg/day MED
- 2013: OH Medical Board recommended a threshold at **80** mg/day MED
<http://www.med.ohio.gov/pdf/NEWS/Prescribing%20Opioids%20Guidlines.pdf>
- American College of Occupational and Environmental Medicine recommended a threshold at **50** mg/day MED
- 2013: IN recommended a threshold at **60** mg/day MED
http://www.in.gov/pla/files/Emergency_Rules_Adopted_10.24.2013.pdf
- 2014: CA Medical Board recommended a yellow flag at **80** mg/day MED
http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf
- 2014: CO Department of Regulatory Agencies recommended a threshold at **120** mg/day MED
<http://1.usa.gov/1DNPaxT>
- 2015: Minnesota Dept of Human Resources limits all opiate prescriptions to a maximum dose of **120** mg/day MED; <http://bit.ly/1RA87AF>
- **CDC guidelines in development (expected Jan, 2016)**

WA (2007) Guidance for Primary Care Providers on More Cautious Use of Opioids for Chronic Non-cancer Pain

- ❑ Establish an opioid treatment agreement
- ❑ Screen for
 - Prior or current substance abuse
 - Depression
- ❑ Use random urine drug screening judiciously
 - Shows patient is taking prescribed drugs
 - Identifies non-prescribed drugs
- ❑ Do not use concomitant sedative-hypnotics
- ❑ Track pain and function to recognize tolerance
- ❑ Seek help if dose reaches 120 mg MED, and pain and function have not substantially improved
- ❑ Use PDMP initially and for monitoring
<http://www.agencymeddirectors.wa.gov/opioiddosing.asp>
MED, Morphine equivalent dose



Open-source Tools Added June 2010

Update of WA AMDG Opioid Dosing Guideline

- ❑ Opioid Risk Tool: Screen for past and current substance abuse
- ❑ CAGE-AID screen for alcohol or drug abuse
- ❑ Patient Health Questionnaire-9 screen for depression
- ❑ 2-question tool for tracking pain and function
- ❑ Advice on urine drug testing

OPIOID DOSE CALCULATOR		
Opioid (oral or transdermal)	Mg per day	Morphine equivalents
codeine		0
fentanyl transdermal (in mcg/hr)		0
hydrocodone	20	20
hydromorphone		0
methadone		
up to 20mg per day		
21 to 40mg per day		
41 to 60mg per day	50	500
>60mg per day		0
morphine		0
oxycodone		0
oxymorphone		0
TOTAL daily morphine equivalent dose (MED) =		520

Available as mobile app:
<http://www.agencymeddirectors.wa.gov/opioiddosing.asp>

Non-fatal Rx Opioid Poisonings in WA Medicaid

There is no safe dose!

- < 50% have chronic opioid use (> 90 days supply)
- 75% of opioid poisonings occurred in cases with prescribed doses < 120 mg MED
- About 45% have sedative-hypnotics in prior month
- 45% have another medication poisoning diagnosis on the same day
- 10-15% have an alcohol diagnosis on the same day
- Most cases have additional opioid prescriptions after poisoning-? **Make overdose hospitalizations reportable to the WA DOH**
- Over 60% of methadone poisonings occurred in cases that did not have a prescription for methadone in the prior year

Interagency Guideline on Prescribing Opioids for Pain (June, 2015)

- Developed by the Washington State Agency Medical Directors' Group (AMDG) in collaboration with an Expert Advisory Panel,
- Actively practicing providers, public stakeholders, and senior state officials.
- <http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>
- *“Written for Clinicians who Care for People with Pain”, 3rd Edition, June, 2015*

2015 WA AMDG Guideline

Because there is little evidence to support long term efficacy of COAT in improving function and pain, and there is ample evidence of its risk for harm, prescribers should proceed with caution when considering whether to initiate opioids or transition to COAT

Although opioids benefit some patients if prescribed and managed properly for appropriate conditions, from a public health perspective, preventing the next group of Washington residents from developing chronic disability due to unnecessary, ineffective, and potentially harmful COAT is a key objective of this guideline

Clinically Meaningful Improvement

- Clinically meaningful improvement is improvement in pain and function of at least 30%
- Assess and document function and pain using validated tools at each visit where opioids are prescribed
- Recommend use of quick and free tools to track function and pain
 - PEG: Pain intensity, interference with Enjoyment of life, and interference with General activity
 - Graded Chronic Pain Scale: Pain intensity and pain interference

Clinically Meaningful Improvement

- A decrease in pain intensity in the absence of improved function is not considered meaningful improvement except in very limited circumstances such as catastrophic injuries (eg, multiple trauma, spinal cord injury, etc)
- Continuing to prescribe opioids in the absence of clinically meaningful improvement in function (CMIF) and pain, or after the development of a severe adverse outcome (eg, overdose event) is not considered appropriate care. In addition, the use of escalating doses to the point of developing opioid use disorder, as defined by DSM-V, is not appropriate

Dosing Threshold

- Avoid COAT if the patient has any FDA or clinical contraindications (e.g. current substance use disorder, past opioid use disorder), history of prior opioid overdose, or pattern of aberrant behaviors
- Use great CAUTION at any dose if the patient has certain risk factors (e.g. mental health disorders, current use of benzodiazepines)
- Do NOT prescribe more than 120 mg/day MED without first obtaining a pain management consult, documented absence of risk factors, and documented CMIF
- **There is no safe opioid dose!!**

Non-Pharmacologic Alternatives

- Do NOT pursue diagnostic tests unless risk factors or specific reasons are identified
- Use interventions such as listening, providing reassurance, and involving the patient in care
- Recommend **graded exercise, cognitive behavioral therapy, mindfulness based stress reduction (MBSR)**, various forms of meditation and yoga or spinal manipulation in patients with back pain
- Address sleep disturbances, BUT, **the greatest risk lies in co-prescribing benzodiazepines and sedative/hypnotics with opioids, even at lower doses of opioids**
- Refer patient to a multidisciplinary rehabilitation program if s/he has significant, persistent functional impairment due to complex chronic pain

Pharmacologic Alternatives

- Use acetaminophen, NSAIDs or combination for minor to moderate pain
- Consider antidepressants (TCAs/SNRIs) and anticonvulsants for neuropathic pain, other centralized pain syndromes, or fibromyalgia
- Avoid carisoprodol (SOMA) due to the risk of misuse and abuse. Do NOT prescribe muscle relaxants beyond a few weeks as they offer little long-term benefit
- Prescribe melatonin, TCAs, trazodone, or other non-controlled substances if the patient requires pharmacologic treatment for insomnia

State Prescription Monitoring Program (PMP)

- Check the PMP with the first prescription to ensure that the patient's controlled substance history is consistent with report
- Check the PMP if prescribing opioids during the sub-acute phase
- Check the PMP at a frequency based on the patient's risk category during chronic therapy to identify aberrant behavior such as multiple prescribers or early fills

Opioid Use in Acute Pain (0-6 weeks)

- The use of opioids for non-specific low back pain, headaches and fibromyalgia is not supported by evidence
- Help the patient set reasonable expectations about recovery
- Reserve opioids for pain from severe injuries or medical conditions, surgical procedures or when alternatives are ineffective. If prescribed, shortest duration and lowest necessary dose
- For minor surgical procedures (eg, impacted wisdom tooth)-prescribe no more than 1-3 days short acting opioid
- Consider tapering off opioids by 6 weeks as acute episode resolved or if CMIF hasn't occurred

Opioid Use in Sub-acute Pain (6-12 weeks)

- Do NOT prescribe opioids if use during acute phase doesn't lead to CMIF
- Screen for depression, anxiety and opioid risk using validated tools
- Avoid prescribing new benzodiazepines and sedative-hypnotics
- Discontinue opioids if there is no CMIF, treatment resulted in severe adverse outcome or patient has a current substance use disorder or a history of opioid use disorder

Opioid Use During Perioperative Period

- Develop a coordinated time-limited treatment plan for managing postoperative pain, including responsible prescriber
- Avoid escalating the opioid dose before surgery
- Do NOT discharge patient with more than 2 weeks supply of opioid. Continued opioid therapy will require appropriate reevaluation by the surgeon
- Taper off opioids added for surgery as surgical healing takes place
 - Major surgeries should be able to be tapered to preoperative doses or lower by 6 weeks
 - For some minor surgeries, it may be appropriate to discharge patients on acetaminophen, NSAIDs only or with a very limited supply of short-acting opioids (e.g. 2-3 days)

Opioid Use in Chronic Pain (>3 months)

- Prescribe COT only if the patient has sustained CMIF, no contraindications and has failed the use of non-opioid alternatives
- Use extreme caution when prescribing COT in high risk patients.
- Use best (monitoring) practices to ensure effective treatment and minimize potential adverse outcomes
- Avoid methadone unless the provider is knowledgeable of the drug and is willing to perform additional monitoring

When to Discontinue Opioids

- Patient request
- No CMIF as measured by validated instruments for at least 3 months during COT
- Risk from continued treatment outweighs benefit, including decrease in function or concomitant medications
- Severe adverse outcome or overdose event
- Non-compliance with DOH's pain management rules or AMDG Guideline
- Urine drug tests (UDT) results and/or patient-specific PMP data are aberrant or unexpected
- Drug-seeking, aberrant, or diversion behaviors

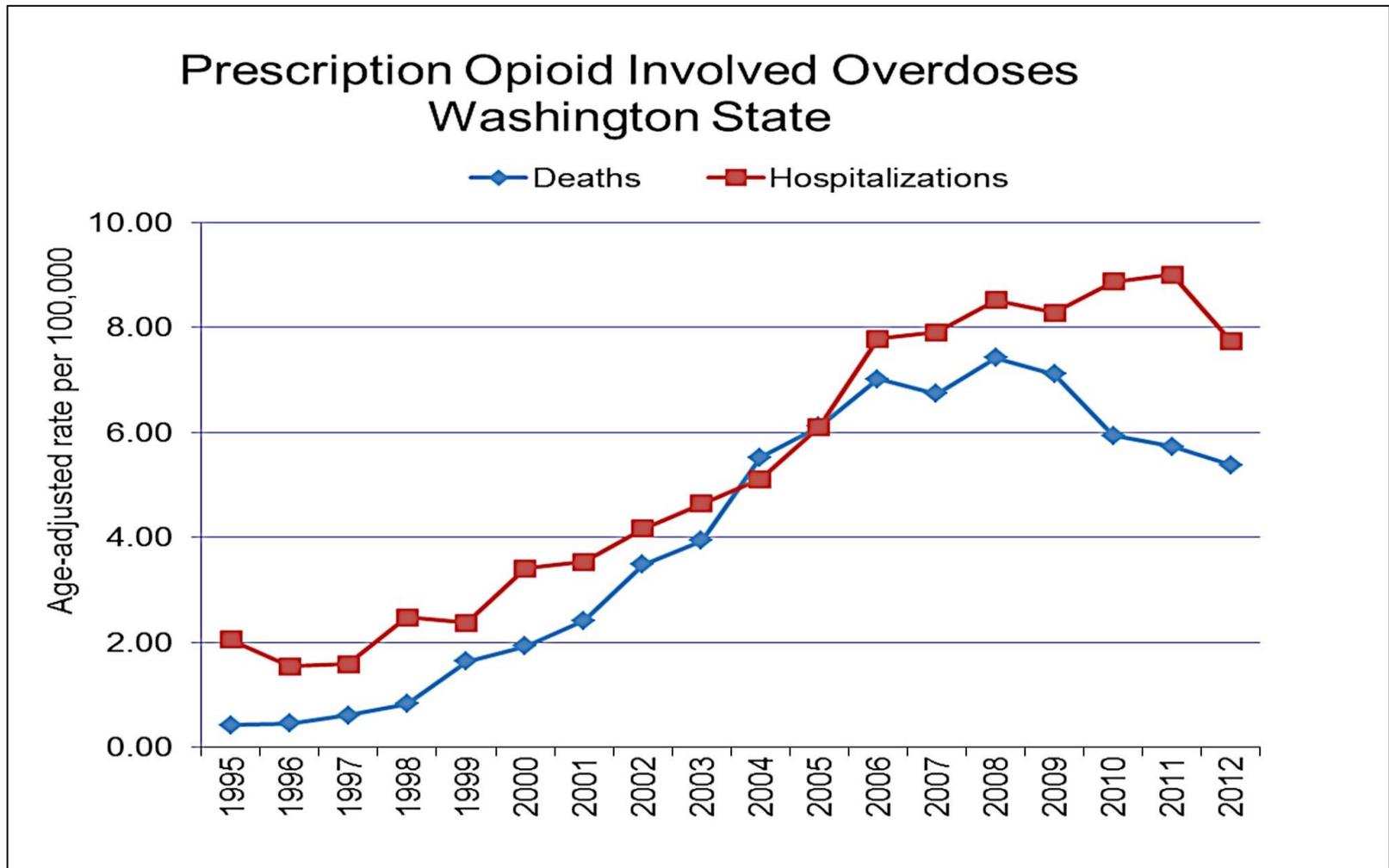
How to Taper Opioids

- Start with a taper of $\leq 10\%$ per week. Rate depends on concurrent treatments or modalities
 - Consider a compulsory taper (2-3 weeks) if the patient does not agree to a voluntary taper or patient with substance use disorder refuse treatment referral
- Prescribe clonidine for withdrawal symptoms such as restlessness, sweating, or tremor
- Use adjunctive therapy during taper or discontinuation (e.g. counseling , psychopharmacological support, SIMP)
- Do NOT reverse taper but it can be slowed. Taper needs to be unidirectional
- Refer patients with opioid use disorder to treatment

Lessons learned from WA effort to reverse opioid epidemic

- ❑ Collaboration among state agencies at the highest levels
- ❑ Reverse permissive laws from late 1990s that did not represent evidence
- ❑ Set opioid dosing and best practice guidelines/rules for acute, subacute and chronic, non-cancer pain
- ❑ Establish metrics for tracking progress; track deaths and overdose ED visits and hospitalizations; track high MED and prescribers
- ❑ Implement an effective Rx monitoring program
- ❑ Encourage/incent use of best practices (web-based MED calculator, use of state PMPs)
- ❑ DO NOT pay for office-dispensed opioids
- ❑ ID high prescribers and offer assistance (e.g., academic detailing, free CME, ECHO)
- ❑ **Incent community-based Rx alternatives (activity coaching and graded exercise early, opioid taper/multidisciplinary Rx later)**
 - ❑ e.g., cognitive behavioral therapy has been found useful in systematic reviews of at least 8 different chronic pain conditions

WA “Bending the Curve” — 30% sustained decline in deaths



Source: Jennifer Sabel PhD, WA State
Department of Health, 2014

Reduce the Development of Preventable Disability

- ❑ Decrease the proportion of injured workers on chronic opioids*

	Baseline: 2012	1Q 2013	2Q 2013	3Q 2013	4Q 2013
Percent of claims received with opioids 6–12 wks from injury	4.9%	4.6%	3.3%	1.4%	1.1%

*2013 opioid guideline for injured workers: <http://1.usa.gov/1nYlarL>

What can PCP do to safely and effectively use opioids for CNCP?

- Opioids not first line Rx for most routine conditions (e.g., MSK, HA, FM)
- Use both pharm and non-pharm alternatives

IF you are using opioids:

- Opioid treatment agreement
- Screen for prior or current substance abuse/misuse (alcohol, illicit drugs, heavy tobacco use)
- Screen for depression
- Prudent use of random urine drug screening (diversion, non-prescribed drugs)
- Do not use concomitant sedative-hypnotics or benzodiazepines
- Track pain and function to recognize tolerance
- Seek help if MED reaches 80 mg/day MED (OH) and pain and function have not substantially improved
- **Use PDMP!**

THANK YOU!

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Substance Abuse and Mental Health Services Administration

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Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



Medication Assisted Treatment: what clinicians need to know

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Topics

- **Forms of medication assisted treatment (MAT)**
- **Provider and Program considerations**
- **Overdose prevention education and naloxone**
- **Screening**
- **Integration**

Medication Assisted Treatment (MAT)

- **Methadone and buprenorphine are approved by the FDA to treat opioid use disorder**
 - *Both are opioid agonists*
- **Extended-release injectable naltrexone is approved by the FDA for the prevention of relapse to opioid use after detoxification**
 - *An opioid antagonist*

Comprehensive Treatment

- **MAT is one component of the comprehensive treatment of opioid use**
- **To be of maximum benefit evidence based behavioral therapy and case management services must also be provided**
- **Not all services have to be delivered by the same provider**

Which MAT to offer?

- **Population served**
 - *Comorbidity (HIV/HSV, Chronic Pain, other substance use disorder)*
 - *Pregnancy*
- **Licensed prescribers**
- **Staffing**
- **Pharmacy**
- **Need to individualize care**

Extended Release Injectable Naltrexone

- **Monthly injection**
- **Patient must be medically detoxed first.**
- **Optimal approach is for patients to receive first dose prior to leaving detox/rehab**
- **Cannot be used by patients who require opioids for pain**
- **Also indicated for alcohol use disorder**

Extended Release Injectable Naltrexone

- **Extended Release Injectable Naltrexone is expensive but covered by many state Medicaid plans**
- **Can be prescribed/ordered by any licensed prescriber including advanced practice nurses and physician assistants**

Naltrexone Resources

P C MAT TRAINING
S S PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

Pcssmat.org

<http://store.samhsa.gov/product/Clinical-Use-of-Extended-Release-Injectable-Naltrexone-in-the-Treatment-of-Opioid-Use-Disorder-A-Brief-Guide/SMA14-4892R>

Clinical Use of Extended-Release
Injectable Naltrexone in the Treatment
of Opioid Use Disorder: A Brief Guide



Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA • 1-877-765-4727

Buprenorphine

Formulated with or without naloxone
buprenorphine monoproduct
(without naloxone) is only for
pregnancy

Few interactions with HIV or HCV meds

Can be used in pregnancy

Does not require detoxification to begin

Generics available

Buprenorphine

- **Requires physician prescriber**
- **Patient capacity limited to 30 per provider for first year. After one year of experience may request increase to 100 patients/per provider**
- **Covered by most state Medicaid**
- **Becoming certified as an opioid treatment program (OTP) removes the patient capacity limit**

Physician requirements to prescribe buprenorphine

- Obtain waiver to Controlled Substances Act by filing “notice of intent to prescribe”
- Licensed and registered with DEA
- One of the following:
 - *Board specialization in addiction medicine or addiction psychiatry*
 - *Completed 8 hour training*
 - *Investigator in trials to approve buprenorphine*
 - *Has training or experience approved by state licensing board.*

Buprenorphine Resources



How to get a waiver and everything else you need.

<http://buprenorphine.samhsa.gov/>

The logo for PCSSMAT (Prescriber Clinical Support System for Medication Assisted Treatment). It features a light blue rectangular background. On the left, the letters "P", "C", "S", and "S" are each inside a white rounded square. To the right of these letters, the word "MAT" is in white text inside a dark purple rounded rectangle, followed by the word "TRAINING" in dark purple text. Below "MAT TRAINING", the text "PROVIDERS' CLINICAL SUPPORT SYSTEM" is in dark purple, and "For Medication Assisted Treatment" is in white.

Required prescriber training
and other resources
pcssmat.org

Methadone

- **Requires certification as an opioid treatment program and program DEA registration**
 - *Dpt.samhsa.gov 240-276-2700*
- **Methadone must be administered and dispensed at the program**



pcssmat.org

Naloxone



SAMHSA
Opioid Overdose
TOOLKIT

Download from SAMHSA store

- **Prescribe to persons at risk for or likely to witness overdose**
- **Consider using standing order**
- **Educate on risk reduction**

ONLINE NALOXONE TRAINING:
http://www.opioidprescribing.com/naloxone_module_1-landing

Motivate to seek MAT

Screening Brief Intervention and Referral to Treatment: SBIRT



SBIRT program and billing information

<http://www.samhsa.gov/sbirt>



<http://attcnetwork.org/national-focus-areas/content.aspx?rc=sbirt&content=STCUSTOM3>

Great training resource!

And:

Resource for hospital SBIRT services: hospitalsbirt.webs.com

SAMHSA-HRSA Center for Integrated Health Solutions

- General resources
- MAT implementation resources
- Resources for physicians

<http://www.integration.samhsa.gov/clinical-practice/mat/mat-overview>

HRSA 16-074 Substance Abuse Treatment Expansion



Grants.gov
Applications due:
September 28th !

<http://bphc.hrsa.gov/programopportunities/fundingopportunities/substanceabuse/index.html>

To Ask a Question

□ Using the Webinar System

- “Click” the Q&A tab at the top left of the webinar tool bar
- “Click” in the white space
- “Type” your question
- “Click” ask

□ On the Phone

- Press Star (*) 1 to enter the queue
- State your name
- Listen for the operator to call your name
- State your organization and then ask your question

Thank you for joining!
Please email us questions at
coca@cdc.gov



Centers for Disease Control and Prevention
Atlanta, Georgia

<http://emergency.cdc.gov/coca>

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Continuing Education guidelines require that the attendance of all who participate in COCA Conference Calls be properly documented. All Continuing Education credits/contact hours (CME, CNE, CEU, CECH, ACPE and AAVSB/RACE) for COCA Conference Calls/Webinars are issued online through the [CDC Training & Continuing Education Online system \(http://www.cdc.gov/TCEOnline/\)](http://www.cdc.gov/TCEOnline/).

Those who participate in the COCA Conference Calls and who wish to receive CE credit/contact hours and will complete the online evaluation by **October 23, 2015** will use the course code **WC2286**. Those who wish to receive CE credits/contact hours and will complete the online evaluation between **October 24, 2015** and **September 23, 2016** will use course code **WD2286**. CE certificates can be printed immediately upon completion of your online evaluation. A cumulative transcript of all CDC/ATSDR CE's obtained through the CDC Training & Continuing Education Online System will be maintained for each user.

Upcoming COCA Call/Webinar registration not required

How To Prevent and Control Pediatric Influenza

- ❑ Date: Thursday, Oct 1, 2015
- ❑ Time: 2:00 – 3:00 pm (Eastern Time)
- ❑ Presenter
 - Dr. Hank Bernstein – American Academy Pediatric



For more information visit:
<http://emergency.cdc.gov/coca>

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