Medication Assisted Therapy:
New Opportunities in the Era of an Opioid Crisis

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Disclosure

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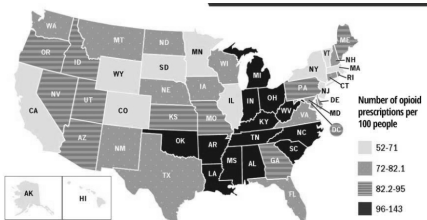
Learning Objectives

- Describe the history of opioid use disorder and legislation associated with treatment
- List the 3 FDA approved medications for opioid use disorder
- Explain the benefits and limitations of each FDA approved medication

Prescribing Patterns: We Play a Role



CE: https://www.cdc.gov/drugoverdose/data/prescribing.html

Here Is What We Know…

- All drug deaths (including ANY drug/medication a patient takes) account for 60,000 to 70,000 annual deaths
- All opioid deaths (including heroin/fentanyl and prescription opioids) account for 30,000 to 40,000

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Now in Comparison

- Hospital-acquired infections deaths: 99,000 annually
- Tobacco, alcohol, guns, and traffic accidents: >700,000 annually

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An Even Closer Look…

- Fentanyl is responsible for 79% of all opioid overdose deaths
  - So your first reaction might be "no one should ever prescribe fentanyl"
- YET, only 5% of all fentanyl overdose deaths are due to pharmaceutical grade fentanyl

BBS Health Education, 2019

Schatman, Zieglar (2017) Pain Management, Prescription Opioid Mortality and the CDC.

It's Not an Opioid Epidemic… But a Polypharmacy Epidemic

72% of deaths involving oxycodone…..

also included alcohol, and/or benzodiazepines, cocaine, kratom, methamphetamine, and other opioids (which may not have been prescribed concurrently)

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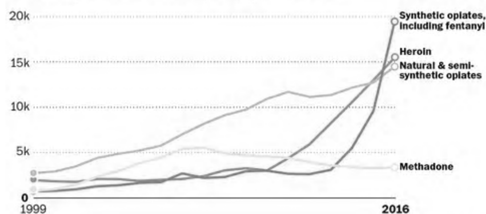
Schatman, Ziegler (2017) Pain Management, Presctiption Opioid Mortality and the CDC.



Some Definitions

- Tolerance: a person's diminished response to a drug that is the result of repeated use
- Physical dependence: caused by changes in the body as a result of constant exposure to a drug
  - –Prednisone…
  - –Abrupt withdrawal of drug causes withdrawal symptoms
- Pseudoaddiction: resulting from practitioners misinterpreting a patient's pain relief seeking behaviors as drug-seeking behaviors common to addiction

Addiction

- A psychological condition that describes a compulsion to take a drug or engage in other harmful behaviors
- The inability to limit or cease substance use
- The irresistible urge to continue seeking and taking the drug despite serious negative consequences
  - –Will do "whatever it takes" to get the drug
  - –CRAVING…

Screening for Opioid Use Disorder

- Recommendation of universal OUD screening
  - –High prevalence of substance use disorders in primary care patient
  - –The effectiveness of medications to treat OUD

Drug Abuse Screening Test (DAST-10)

- 10 questions developed from original 28 to identify drug-use problems in past year
- Self-administered, interview
- Used with adults
- Good sensitivity
- Spanish version available

These Questions Refer to the Past 12 Months			
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop using drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?	Yes	No

DAST 10 Scoring

Interpretation (Each "Yes" response = 1)

Score	*Degree of Problems Related to Drug Abuse*	*Suggested Action*
0	No Problems Reported	None At This Time
1-2	Low Level	Monitor, Reassess At A Later Date
3-5	Moderate Level	Further Investigation
6-8	Substantial Level	Intensive Assessment

CAGE-AID

1. Have you ever felt you should **cut down** on your drinking or drug use?
2. Have people **annoyed** you by criticizing your drinking or drug use?
3. Have you ever felt bad or **guilty** about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning **(eye opener)** to steady your nerves or to get rid of a hangover?

"0" for no and "1" for yes. A score of 1 or above accurately detects 91% of alcohol users and 92% of drug users. A score of 2 or greater is considered clinically significant.

Hinkin, 2001, Buschsbaum et. al., 1992; Booth, et. al., 1998

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Brief Intervention

The nurse practitioner reviews the results of the screening tool with the patient and delivers brief intervention

Referral to Treatment

Provide a referral to treatment or provide the patient with resources they could use in the future

…It May Be You!!

KNOW RESOURCES IN YOUR AREA

Consider insurance/payer barriers

Acute Opioid Withdrawal Symptoms

- Pupillary dilation
- Watery eyes
- Runny nose
- Muscle spasms (“kicking”)
- Yawning, sweating, chills, gooseflesh
- Stomach cramps, diarrhea, vomiting
- Restlessness, anxiety, irritability

Usually result in further use to quiet symptoms

It’s a New Day

- DATA Act of 2000 – Drug Addiction Treatment Act
- Allowed qualified **PHYSICIANS** to dispense or prescribe specifically approved Schedule **III, IV, and V** narcotic medications in settings OTHER THAN an opioid treatment program

16 years later….

CARA Act – Comprehensive Addiction and Recovery Act

- –Signed into law July 22, 2016
- –Extending the privilege of prescribing buprenorphine in office based settings to qualifying nurse practitioners (NPs) and physician assistants (PAs) until October 1, 2021

Be aware of any state law regarding the treatment of addiction/OUD

- Be licensed under state law to prescribe Schedule III, IV, or V medications for pain
- Complete 24 hours of appropriate education through a qualified provider – AANP CE center
- If required by state law, be supervised or work in collaboration with a qualified physician to prescribe medications for the treatment of OUD

In Order to Qualify

- Once training completed, may seek to obtain a DATA 2000 waiver for up to 30 patients, then up to 100 patients after 1 year
- DEA will assign the NP or PA a special identification number. DEA regulations require this number to be included on all buprenorphine prescriptions for opioid dependency treatment

Are we just replacing one medication for another?....

- 80%-90% relapse without it
- Increase in treatment retention
- 80% decrease in drug use and crime
- 70% reduction in death rate

Medications for the treatment of opioid use disorder were NEVER intended to stand alone…

Prescribing should always be paired with cognitive behavioral therapy and counseling

Medications Indicated for Opioid Use Disorder

- Naltrexone – antagonist
- Buprenorphine – partial agonist – CARA Act 2016
- Methadone – agonist – not included in DATA Act of 2000

Oral Naltrexone Dosing

- 50 mg daily, 100 mg every other day or 150 mg every 3 days
- Caveat: induction requires 5-7 days abstinence from heroin or short acting opioid (hydrocodone or oxycodone) and 7-10 days from buprenorphine and methadone

… As patient will experience significant opioid withdrawal if not…

Advantages of Naltrexone

- Safe to use, no abuse potential
- Blocks the effects of opioids
- Reduces danger of accidental overdose
- No physical dependence
- Little or no stigma in the recovery community

Limitations of Naltrexone

- Less research and clinical experience
- No reinforcing effects to support retention in treatment
- No withdrawal symptoms to prevent treatment drop-out
- High cost limits access
- May not control cravings
- Must be opioid free for induction, indication is for relapse prevention

Methadone Hydrochloride

- Full opioid agonist – long, variable unpredictable half-life (20-120 hrs)
- Onset of action: 30-60 mins
  - Duration of action: 24-36 hrs in OUD
  - 6-8 hrs in chronic pain use
- Dosing for OUD:
  - 20-40 mg for acute withdrawal
  - >80 mg for craving
- QTC prolongation risk, torsades de pointes

Methadone Replacement Therapy vs No Opioid Replacement Therapy

- Authoritative review of 11 randomized clinical trials with 1,969 patients
- Conclusion methadone is superior to placebo in:
  - Retaining patients in treatment
  - Reducing illicit opioid use

Mattick, Kimber, Breen, Davoli 2009

Advantages of Methadone

- 70% or more treatment retention at 1 year
- Treats craving
- Blocks illicit opioid use
- Over 40 years of research and treatment experience demonstrating effectiveness
- Significantly reduces risk for addiction related death and health problems
- Medication cost is minimal

Limitations Methadone Maintenance Treatment

- Methadone dispensing or prescribing for opioid use disorder limited to opioid treatment programs
- It is ILLEGAL to prescribe methadone for OUD…
  it may still be prescribed by pain specialists in the treatment of chronic pain
- Stigma
- Potential for abuse
- Patient burden of compliance

Buprenorphine

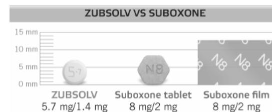
- Partial mu agonist
- Blocks most effect of other opioids if taken due to high affinity for and slow dissociation from the mu opioid receptor
- Schedule III (vs methadone Schedule II)

Buprenorphine Formulations

- Approved for mod to severe OUD (off label for pain)
  - Sublingual (held under tongue for several mins)
    - Combination: buprenorphine/naloxone
    - Monotherapy: buprenorphine
  - Newest approved: implantable and once monthly injectable
- Approved for pain and NOT OUD
  - Parenteral form
  - Transdermal 7 day patch (Butrans)
  - Buccal formulation (Belbuca)

Buprenorphine: A Partial Agonist

SUBOXONE® (buprenorphine and naloxone) Sublingual Film (CIII) comes in a broad range of dose strengths[1]
2 mg / 0.5 mg
4 mg / 1 mg
8 mg / 2 mg
12 mg / 3 mg



Buprenorphine Oral or Film Dosing

- Induction: 2-4 mg up to 8 mg daily
- Maintenance: dose ranges from 8-24 mg daily with target dose of 16 mg daily
- Injectable and implantable options utilized once on stable maintenance dosing

Buprenorphine Maintenance vs Placebo vs Methadone Maintenance for Opioid Withdrawal

- Review of 24 randomized clinical trials with 4,497 patients
- Conclusion buprenorphine is superior to placebo and to moderate dose methadone:
  - Retaining patients in treatment
  - Reducing illicit opioid use

Mattick, Kimber, Breen, Davoli 2008

Advantages of Buprenorphine

- DATA 2000 greatly increases access
- Less severe dependency allows for easier transitions between recovery with and without medication
- Partial agonist is safer with less overdose potential
- Lower abuse potential
- People live a normal life free from craving and withdrawal
- SAVES LIVES

Limitation of Buprenorphine

- Not a full agonist and does not retain people in treatment as well as full agonist
- Has diversion potential and may be misused
- Medication is expensive and access is limited
- Stigma in the recovery community

No One Treatment is Right for Everyone

- 3 FDA-approved medications to support recovery
- Numerous ways to integrate pharmacotherapies & behavioral interventions
- 3 MAT approaches available in Douglas County

Clinical Pearls

- Screen patient for addiction, with goal of early referral
- Brief questionnaire can be included in the wellness questionnaire that patient can fill out while waiting
- Know your state guidelines… AANP offers the 24 hour waiver education needed to prescribe MAT

References

- Nurse Practitioner and Physician Assistants Prescribing Buprenorphine.(2016) https://www.asam.org/resources/practice-resources/nurse-practitioners-and-physician-assistants-prescribing-buprenorphine
- SBIRT Oregon Primary Care (2015) Training curriculum. Retrieved from http//www.sbirtoregon.org/
- ASAM (American Society of Addiction Medicine) (2015) The ASAM National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use.
- Teaching SBIRT: SAMSHA Core Curriculum (2014) Rockville, MD: SAMSHA

I am happy to take questions!

Thank You!

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