More of the Solution

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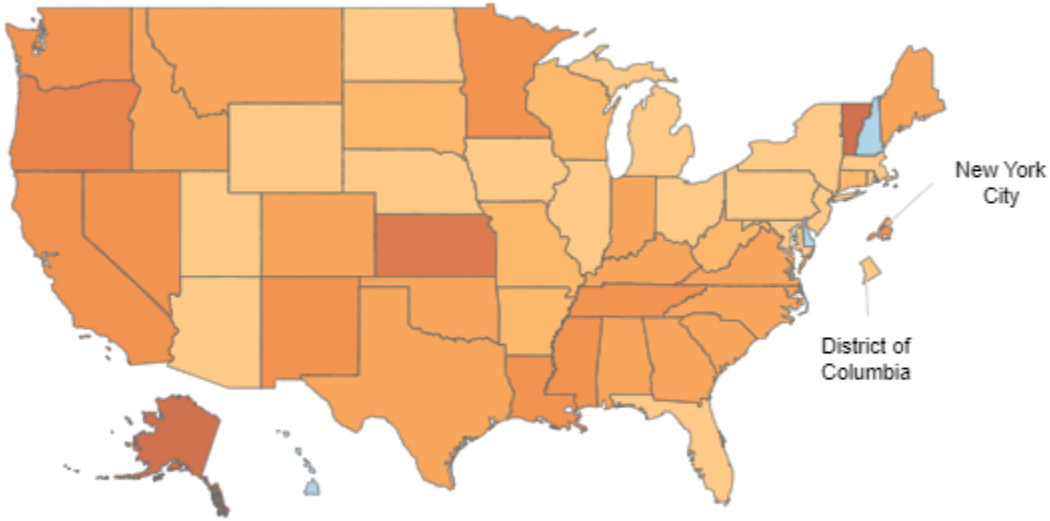
March 2022

CDC: 104,288 Fatal Overdoses

Figure 1b. Percent Change in Predicted 12 Month-ending Count of Drug Overdose Deaths, by Jurisdiction: September 2020 to September 2021



Legend for Percent Change in Drug Overdose Deaths Between 12-Month Ending Periods

-8.9 — 80.1

Select predicted or reported number of deaths

- (•) Predicted
- ( ) Reported

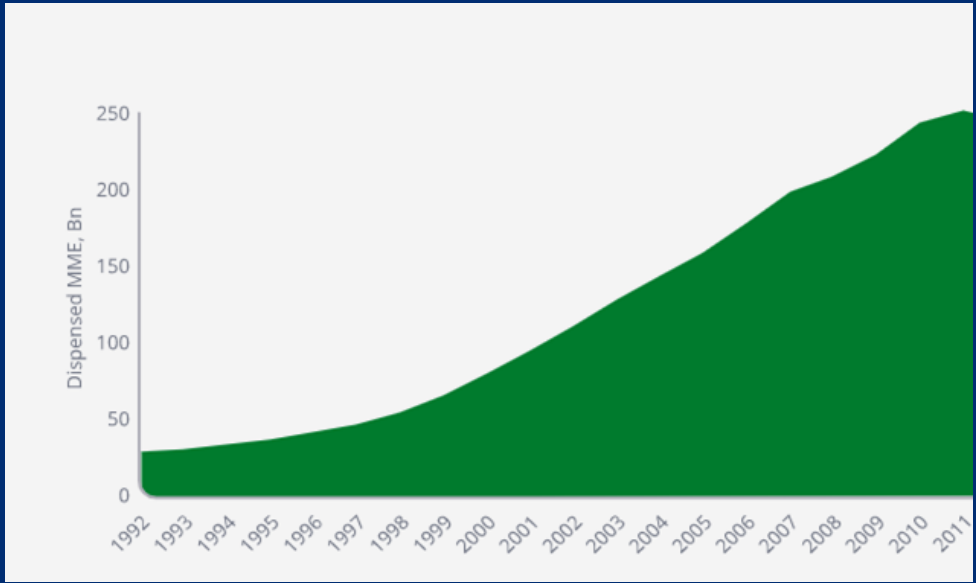
Percent Change for United States

15.9 ▲

“We started it”: Atul Gawande on doctors’ role in the opioid epidemic

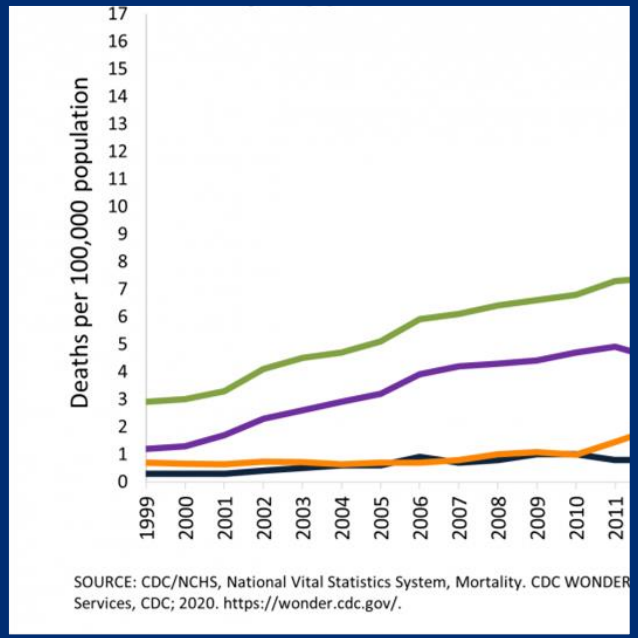
By Sarah Kliff | sarah@vox.com | Updated Sep 8, 2017, 5:25pm EDT

1992-2011: Nearly 10-fold increase in Opioids Dispensed



Source: IQVIA, MME basis

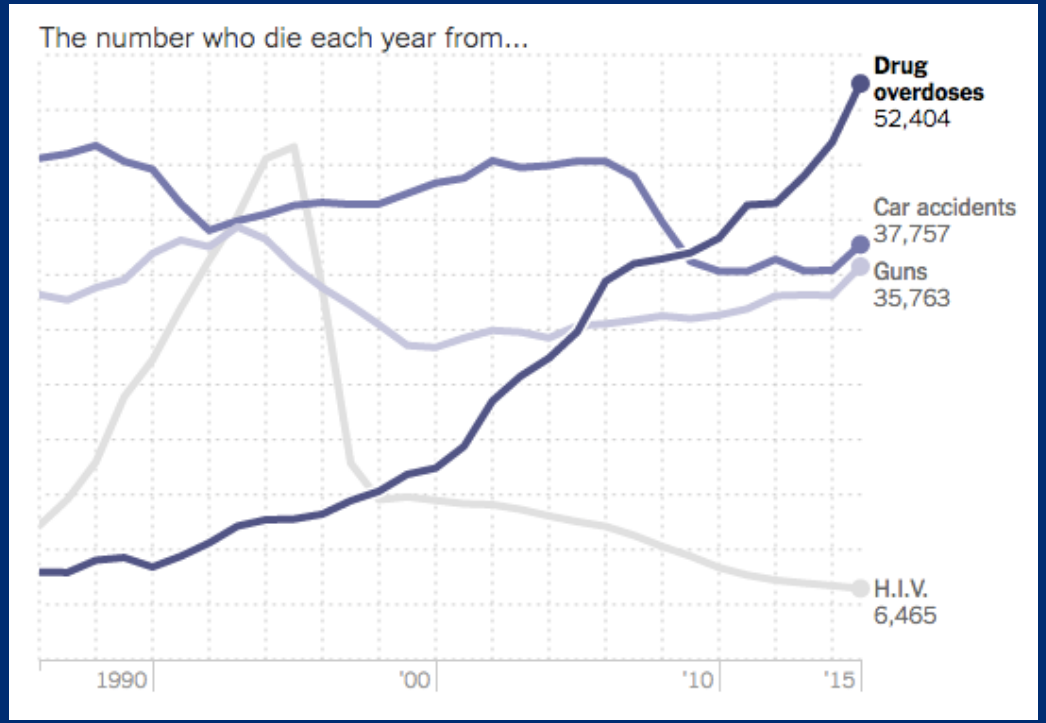
Initial Wave: Prescription Opioid Overdoses



All Opioid Overdoses

Prescription Opioid Overdoses

Too Late, a Crisis Is Recognized



New York Times

Boards Respond

State Requirements for Pain Management CME

New York	3 hours Prescribers who have a DEA registration number to prescribe controlled substances, as well as residents who prescribe controlled substances under a facility DEA registration number, must complete at least 3 hours in pain management, palliative care, and addiction.
New York (PA)	3 hours every 3 years Controlled substance prescribers are required at least 3 hours of training in pain management, palliative care, and addiction by July 1, 2017, and every three years thereafter.
North Carolina	3 hours every 3 years Physicians who prescribe controlled substances must complete at least 3 hours of Category 1 CME designed to address controlled substance prescribing practices and shall include instruction on controlled substance prescribing practices, recognizing signs of the abuse or misuse of controlled substances, and controlled substance prescribing for chronic pain management.
North Carolina (PA)	2 hours every 2 years Licensees authorized to prescribe controlled substances are required 2 hours in controlled substances every renewal.
Ohio	20 hours every 2 years Physician owners/operators of pain management clinics must complete 20 hours of Category 1 CME in pain medicine every 2 years, to include one or more courses addressing the potential for addiction.
Ohio (PA)	12 hours every 2 years PAs authorized to prescribe must complete 12 hours in pharmacology pertaining to medicine/medications from an accredited institution recognized by the state medical board every two years.
Oklahoma (MD)	1 hour every 3 years Licensees must complete at least 1 hour of education in pain management OR 1 hour of education in opioid use or addiction in each renewal cycle unless the licensee has demonstrated to the satisfaction of the Board that the licensee does not currently hold a valid federal DEA registration number.
Oklahoma (DO)	1 hour, every 2 years Osteopathic physicians must earn 1 hour on prescribing, dispensing, and administering controlled substances.
Oklahoma (PA)	1 hour, every 2 years PAs must earn 1 hour of Category 1 CME on the topic of substance abuse.
Oregon	6 hours one time Licensees must complete a 1 hour course on pain management and a minimum of 6 CME credit hours in the subject of pain management and/or the treatment of terminally ill and dying patients. Exceptions include licensees holding Lapsed, Limited, Telemedicine, Telradiology, or Telemonitoring licenses.
Oregon (PA)	6 hours one time There is a one-time requirement of 6 hours in pain management and/or treatment of the terminally ill and dying patients. An additional 1 hour must be specific to Oregon provided by the Pain Management Commission of the Department of Human Services.
Pennsylvania (MD/DO)	4 hours, once, for initial licensure; 2 hours, every 2 years Within 12 months of initial licensure, licensees must take 2 hours of CME on pain management or identification of addiction, as well as 2 hours on practices of prescribing or dispensing opioids. Subsequent license renewals require 2 hours of CME on pain management, identification of addiction, or prescribing practices.
Pennsylvania (PA/CPA)	2 hours, every 2 years Licensees with prescriptive authority, as a condition of license renewal, are required 2 hours in pain management, the identification of addiction or the practices of prescribing or dispensing of opioids.
Rhode Island	4 hours every two years AMA Category 1 or AOA Category 1A credits on pain management, universal precautions, infection control, modes of transmission, bioterrorism, end of life education, palliative care, OHSA, or ethics.
Rhode Island (PA)	8 hours one-time Effective January 2, 2020, licensees who prescribe Schedule II opioids have a one-time requirement of 8 hours of Category I CME in any or all of the following topics: The appropriate prescribing of opioids for pain; Pharmacology; Adverse events; Potential for dependence; Tolerance; Substance use disorder; and Alternatives to opioids for pain management.
South Carolina	2 hours every 2 years Licensees must complete at least 2 hours of Category 1 credits related to approved procedures for prescribing and monitoring schedules II-IV controlled substances.
South Carolina (PA)	4 hours every 2 years All licensees who are authorized to prescribe controlled substances are required 4 hours of controlled substance education every renewal.
Tennessee (MD)	2 hours every 2 years Licensees must complete 2 hours on controlled substance prescribing, including instruction in the Department's treatment guidelines on opioids, benzodiazepines, barbiturates, and carisoprodol and may include topics such as addiction, risk management tolls, and other topics approved by the Board. Providers of intractable pain treatment must have specialized CME in pain management.
Tennessee (DO)	2 hours every 2 years At least 2 credit hours must be a course(s) designated to address prescribing practices.
Tennessee (PA)	3 hours every 2 years All licensees are required 3 hours of prescribing controlled substances which must include instruction in the TN Chronic Pain Guidelines.
Texas	2 hours every 2 years Licensees must complete 2 AMA Category 1 or AOA Category 1A hours on medical ethics and/or professional responsibility, including, but not limited to, risk management, domestic abuse, or child abuse. Licensees practicing in a pain management clinic must complete 10 hours of CME annually in the area of pain management.
Texas (PA)	2 hours every 2 years Beginning with 2021 renewals and annually thereafter, licensees practicing direct patient care must complete 2 hours of Category 1 credit covering safe and effective pain management related to the prescription of opioids and controlled substances. Additionally, licensees authorized to prescribe or dispense opioids shall annually attend at least 1 hour covering best practices and topics related to pain management and treatment options.
Utah (MD/DO)	3.5 hours Controlled substance prescribers must complete at least 3.5 hours of continuing education in 1 or more controlled substance prescribing classes.
Utah (PA)	4 hours every 2 years All controlled substance prescribers must complete 4 hours in controlled substance prescribing every renewal, .5 of which must be completed through an online tutorial and test, as described by the Board in section 58.56.402.* The remaining 3.5 hours may be completed through an AAPA PAA Category 1 Credit™ course that meets Board requirements. *The online tutorial and test may only be offered by the Division of Occupational and Professional Licensing. Access the training here: https://dopl.utah.gov/cst/index.html.
Vermont (MD)	3 hours every 2 years Licensees must earn 1 hour on hospice, palliative care, or pain management services. Additionally, each licensee who holds a DEA registration number must earn at least 2 CME hours on the safe and effective prescribing of controlled substances and pain management.
Vermont (PA)	2 hours every 2 years Beginning with 2018 renewals, all licensees who prescribe controlled substances must show evidence of 2 hours related to the safe and effective prescribing of controlled substances.
Virginia	2 hours every 2 years Licensees must earn 2 hours in pain management, proper prescribing of controlled substances and the diagnosis and management of addiction.
Virginia (PA)	2 hours every 2 years Effective July 1, 2019, prescribers are required 2 hours in topics related to pain management, responsible prescribing of covered/controlled substances, and diagnosis and management of addiction every renewal.
Washington (MD/DO/PA)	1 hour, one-time requirement Effective January 1, 2019, any physician licensed to prescribe opioids must complete a 1 hour CE requirement regarding best practices in the prescribing of opioids or the opioid prescribing rules of the Washington Administrative Code.
West Virginia (MD/DO/PA/CRPA)	3 hours, every 2 year renewal cycle Physicians who have prescribed, administered, or dispensed any controlled substance pursuant to a West Virginia license in the two-year license cycle preceding renewal, are required to complete 3 hours of Board-approved CME in drug diversion training and best practice prescribing of controlled substances training during each reporting period.
Wisconsin	2 hours every 2 years Licensees must complete 2 hours of Category 1 hours on the opioid prescribing guidelines issued by the Board.

Source of state requirements: Federation of State Medical Boards (FSMB)

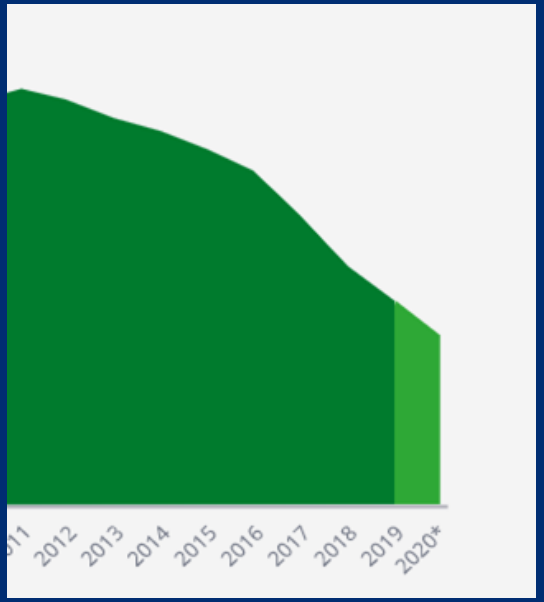
FSMB Releases Updated Guidelines for Chronic Use of Opioid Analgesics

Safe Opioid Prescribing Initiative - North Carolina Medical Board

Prescribing Resources

Opioid Toolkit

…And Then?



prescribing falls

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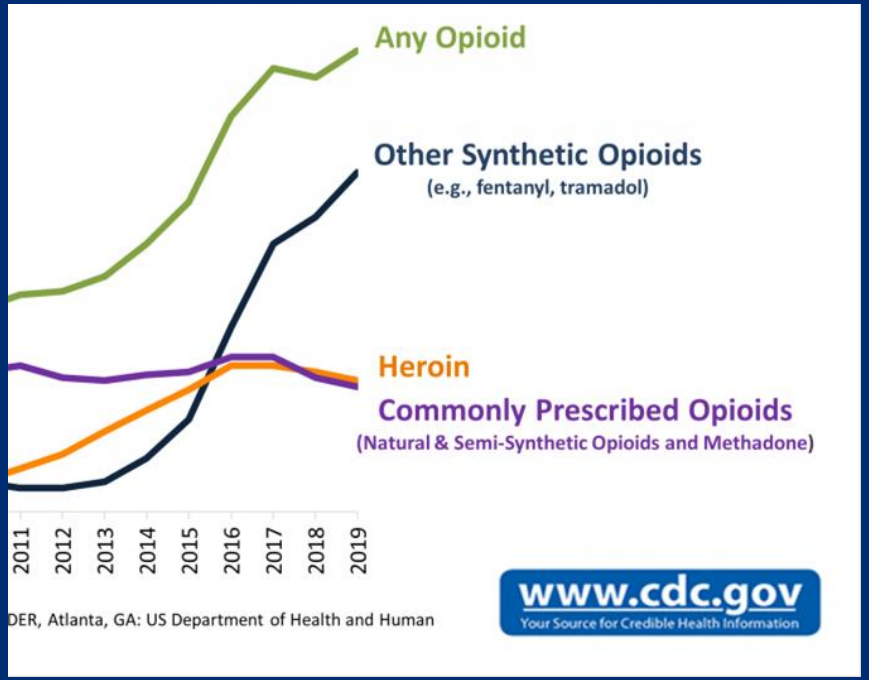
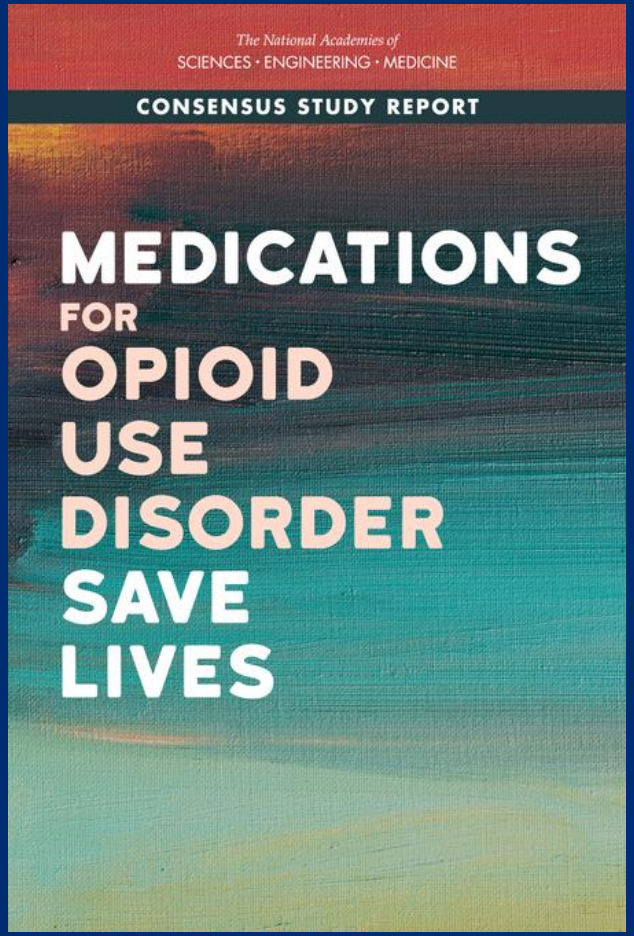


deaths rise

Drug users switch to heroin because it's cheap, easy to get

It's not enough to be less of the problem.

More of the Solution: Effective Treatment



Topics

1. Medication for Opioid Use Disorder Saves Lives
2. There Are Too Few Prescribers
3. How Boards Can Be More of the Solution

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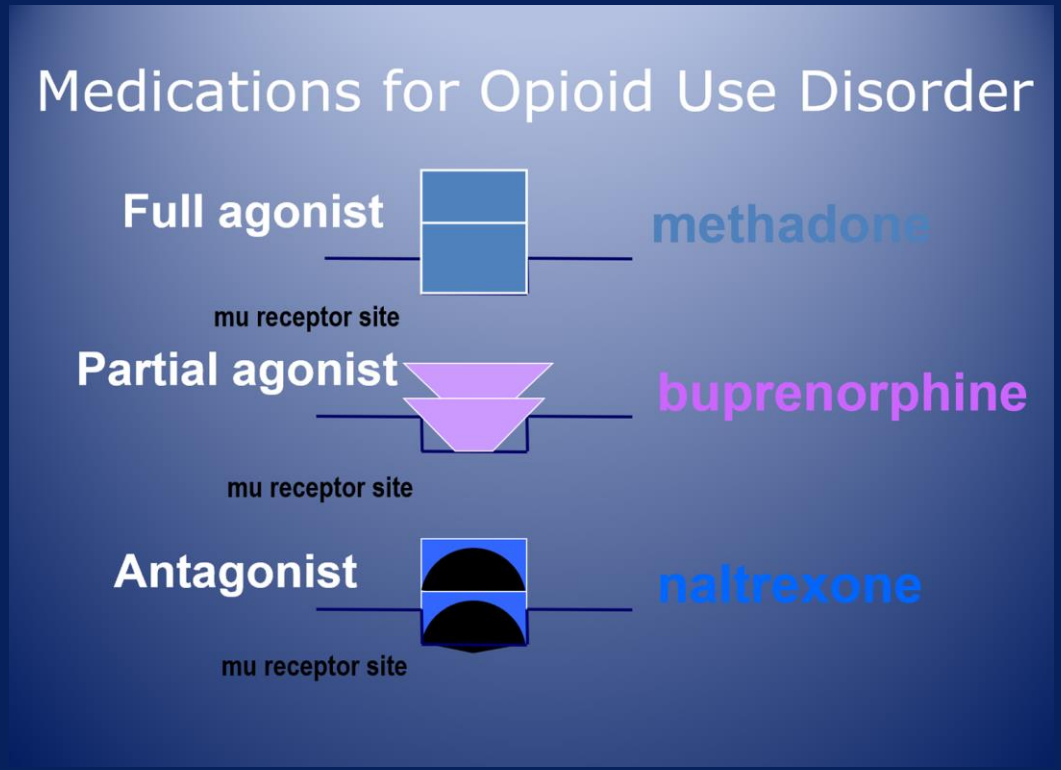
How do medications for opioid addiction work?



All 3 medications work at the level of the opioid receptors to reduce cravings.

None of the medications produce euphoria for patients at therapeutic doses.

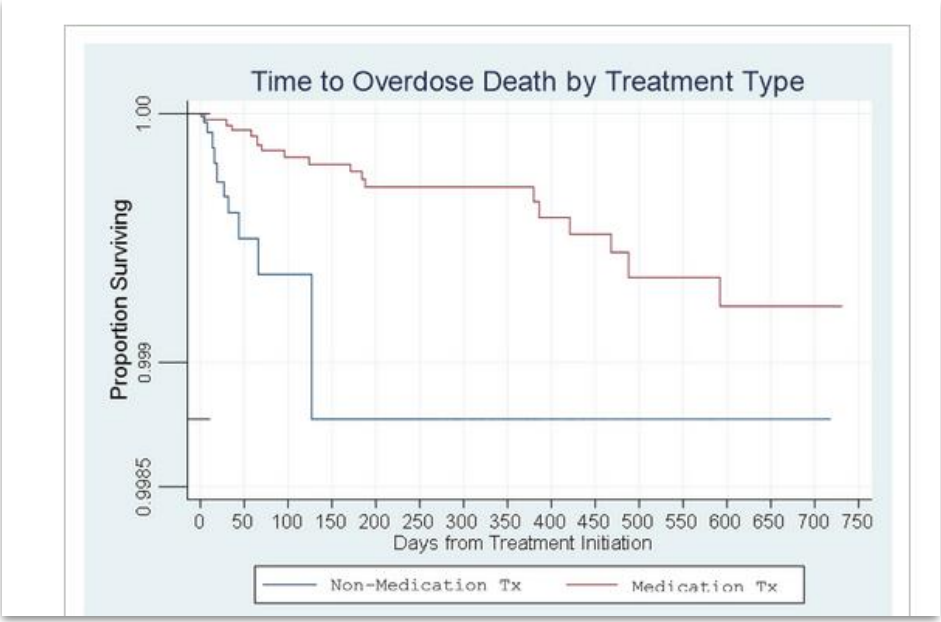
None of the medications produce fatigue at therapeutic doses.

Using medications as treatment is not addiction.

What's the evidence in support of medication treatment?

	Depot Naltrexone	Buprenorphine	Methadone
Reduces Cravings	✓	✓	✓
Reduces Misuse	✓	✓	✓
Reduces Overdose		✓	✓
Reduces Infectious Disease		✓	✓
Reduces Mortality		✓	✓
Increases Employment		✓	✓
Reduces Criminality			✓
Track record > 20 years			✓

Maryland: **80% Reduction** in Overdose Fatality Risk With Methadone and Buprenorphine



Baltimore City: Major Decline in Overdose as Treatment

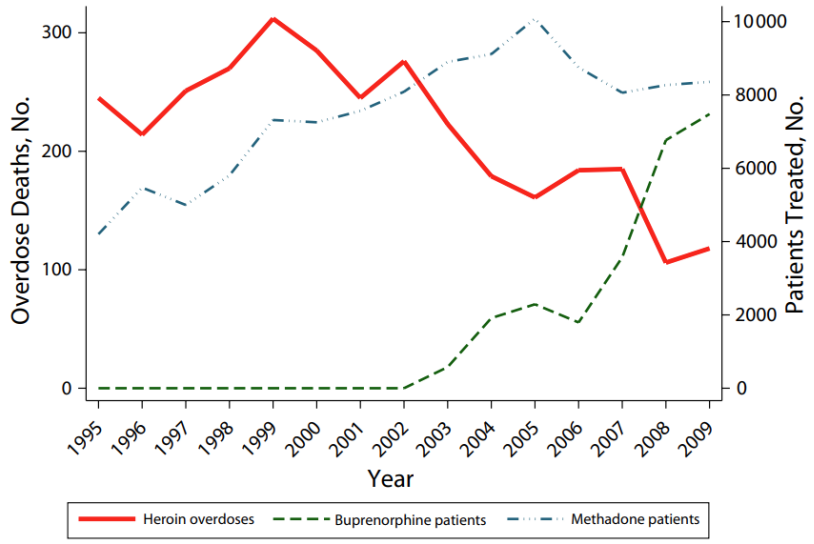


FIGURE 1—Heroin overdose deaths and opioid agonist treatment: Baltimore, MD, 1995–2009.

Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995–2009

Robert P. Schwartz, MD, Jan Gryczynski, PhD, Kevin E. O'Grady, PhD, Joshua M. Sharfstein, MD, Gregory Warren, MA, MBA, Yngvild Olsen, MD, Shannon G. Mitchell, PhD, and Jerome H. Jaffe, MD

Topics

1. Medication for Opioid Use Disorder Saves Lives
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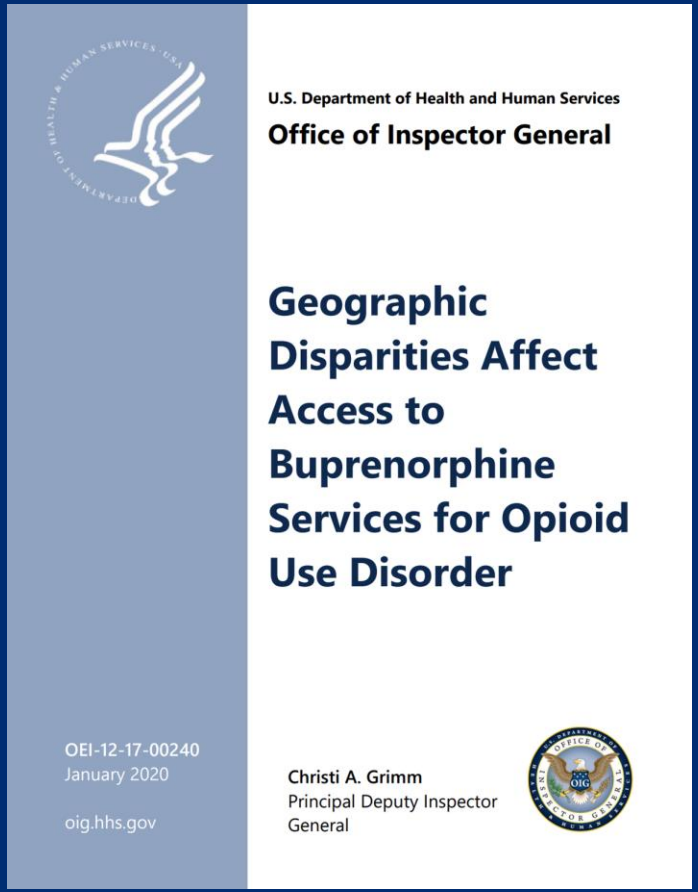
Too Few Prescribers in Outpatient Treatment

- **40% of US counties** do not have a single waivered buprenorphine provider in 2018.
- Among 1,100 counties with the greatest need for buprenorphine services, 56% likely had inadequate capacity.



Too Few Prescribers in Residential Treatment

- For residential treatment admissions for opioid use, only **17.7%** received medications in states that expanded Medicaid.
- In states that did not expand Medicaid, the rate of medication treatment was **1.9%.**

Original Investigation | Psychiatry

February 7, 2020

Differences in Availability and Use of Medications for Opioid Use Disorder in Residential Treatment Settings in the United States

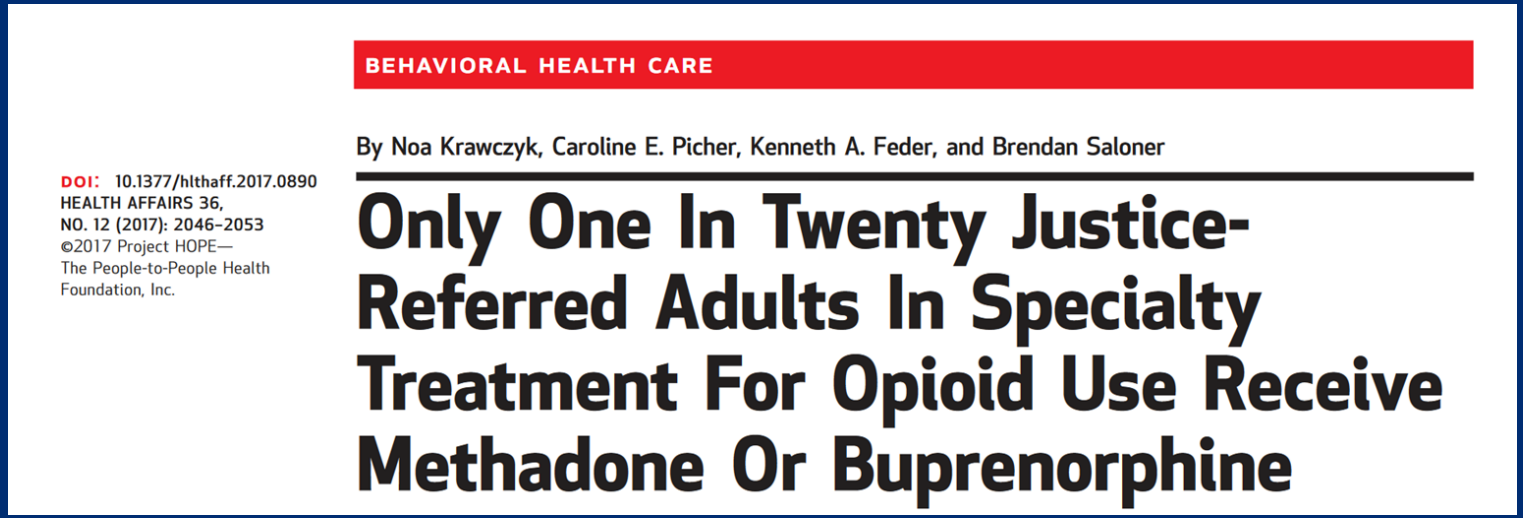
Andrew S. Huhn, PhD, MBA[1,2]; J. Gregory Hobelmann, MD, MPH[1,2]; Justin C. Strickland, PhD[1]; et al

Too Few Prescribers in Emergency Departments

- More than 1 in 20 patients with nonfatal overdoses will be dead in a year.
- Yet relatively few Emergency Departments routinely offer access to buprenorphine treatment, which dramatically reduces the risk of death.

http://americanhealth.jhu.edu/addiction-emergency

Too Few Prescribers in the Criminal Justice System



BEHAVIORAL HEALTH CARE

By Noa Krawczyk, Caroline E. Picher, Kenneth A. Feder, and Brendan Saloner

Only One In Twenty Justice-Referred Adults In Specialty Treatment For Opioid Use Receive Methadone Or Buprenorphine

DOI: 10.1377/hlthaff.2017.0890
HEALTH AFFAIRS 36,
NO. 12 (2017): 2046–2053

Why So Few Prescribers?

VIEWPOINT

Confronting the Stigma of Opioid Use Disorder—and Its Treatment

Yngvild Olsen, MD, MPH
Institutes for Behavior Resources Inc, Baltimore, Maryland.

Joshua M. Sharfstein, MD
Maryland Department of Health and Mental Hygiene, Baltimore.

The death of Philip Seymour Hoffman from a heroin overdose tragically adds another name to the list of celebrities who have lost their lives to addiction. Increasing numbers of overdoses from prescription opioids and a more recent increase in heroin-associated fatalities have caused heartbreak in communities across the country. More than 30 000 deaths from unintentional drug overdose were reported in the United States in 2010, the most recent year for which data are available.[1]

treatment approach supported by the same level of evidence.

Nonetheless, there is significant resistance to the treatment of opioid use disorder with medications. For instance, some communities have opposed having medication-assisted treatment services located in their neighborhoods, some local officials have proposed legislation in violation of the Americans with Disabilities Act that would change zoning codes to exclude medication-assisted treatment centers, some health insurers have

Why So Few Prescribers?

"Less than 30% of primary care providers reported they were willing to have a person taking medication for opioid use disorder as a neighbor or marry into their family … Greater stigma was associated with an 11 percentage point lower likelihood that primary care providers prescribed [medication treatment] and with lower support for policies intended to increase access to [medication treatment]."

The role of stigma in U.S. primary care physicians' treatment of opioid use disorder

Elizabeth M. Stone [a,b,*], Alene Kennedy-Hendricks [a,b], Colleen L. Barry [a,b], Marcus A. Bachhuber [c], Emma E. McGinty [a,b]

In 2020, 11.2% of people with an opioid use disorder received medication treatment.

NSDUH 2020, Table 5.42B.

Topics

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Board Agenda

1. Educate board members about medication treatment
2. Publicly endorse medication treatment
3. Advocate for training of prescribers in professional schools and residencies
4. Require CE for medication treatment

Board Agenda

5. Make sure health professionals with opioid use disorder have access to lifesaving medication treatments.

RAMP
RECOVERY & MONITORING PROGRAM
INSTITUTE FOR NURSING

2015 Guide:

Participants cannot work while taking medication assisted treatment such as Methadone, Suboxone and other drugs in this class.

2020 Guide:

Participants cannot work while taking medication assisted treatment. Cases will be reviewed by the RAMP team.

The Case for Buprenorphine and Methadone in Professional Programs

1. Saves lives
2. Sustains recovery = better for patient care
3. Respects clinicians

The Case for Buprenorphine and Methadone in Professional Programs

4. Reduces stigma

PERSPECTIVE

PRACTICING WHAT WE PREACH

Practicing What We Preach — Ending Physician Health Program Bans on Opioid-Agonist Therapy

Leo Beletsky, J.D., M.P.H., Sarah E. Wakeman, M.D., and Kevin Fiscella, M.D., M.P.H.

The Case for Buprenorphine and Methadone in Professional Programs

5. Less legal liability

According to the Legal Action Center, it would **violate the Americans with Disabilities Act** for a state licensing board to deny licensure or take disciplinary action against a health care professional because they receive appropriate medication treatment.

It also would be discriminatory for a licensing board to mandate a health professional into a professional assistance program that does not permit appropriate medication treatment.

The Case Against Buprenorphine and Methadone in Professional Programs

1. Not needed as outcomes are terrific as is
2. Impairment
3. Naltrexone is just as good
4. "Even one bad outcome" and it threatens the whole professional program

A Closer Look

"Outcomes are terrific."	Outcomes could be much better, including fewer drop-outs and fewer people dissuaded from even trying to return to work.
Impairment	Mixed evidence on effects, and unlikely to be worse than many other commonly prescribed medications. Best to assess on individual basis.
Naltrexone is just as good.	Evidence for naltrexone much less strong, and regardless, patients should get what's right for them.
"Even one bad outcome."	Every reason to believe medications will lower the number of bad outcomes.

ASAM American Society *of* Addiction Medicine

Public Policy Statement on Physicians and other Healthcare Professionals with Addiction

Healthcare professionals should be offered the full range of evidence-based treatments, including medication for addiction, in whatever setting they receive treatment. Regulatory agencies (including state licensing boards), professional liability insurers, and credentialing bodies should not discriminate against the type of treatment an individual receives based on unjustified assumptions that certain treatments cause impairment.

Journal of Medical Toxicology
https://doi.org/10.1007/s13181-021-00861-4

POSITION STATEMENT

ACMT Position Statement: Allow Optimal Treatment for Healthcare Professionals with Opioid Use Disorder

Ryan T. Marino[1] · Meghan Spyres[2,3] · Timothy J. Wiegand[4] · Kavita M. Babu[5] · Andrew Stolbach[6]

Received: 17 September 2021 / Revised: 4 October 2021 / Accepted: 6 October 2021

Keywords Opioid use disorder · Health care professionals · Physicians · Buprenorphine · Impairment

"Buprenorphine and methadone are lifesaving treatments for opioid use disorder. Health care professionals should have access to the best treatments, including opioid agonist medications."

More of the solution.

Questions?

Acknowledgements:

➔ Matthew Salzman, M.D.