Episode 24 – Medication for opioid use disorder: Our best chance to turn the tide on overdose deaths

Intro music: 0:00

Podcast introduction: 0:09
For the past couple of years, the opioid overdose crisis has understandably taken a backseat to COVID-19. But of course, it didn't go away. Sadly, opioid overdose visits to North Carolina emergency rooms have continued to rise. And while overdose deaths in our state fell in 2018 and plateaued in 2019, they rose 40% in 2020, according to data released in March by the North Carolina Department of Health and Human Services. This is Jean Fisher Brinkley, Communications Director for the North Carolina Medical Board and this is MedBoard Matters. Now, a lot of the medical board's early work related to the opioid crisis was aimed at reducing inappropriate and excessive prescribing while also educating controlled substances prescribers about accepted standards of care. But the second front in the fight against opioid overdose has always been expanding access to treatment for patients with opioid use disorder. This has become especially critical as the overdose epidemic has shifted, with the majority of deaths now linked to illicit opioids, rather than opioids prescribed by a licensed medical professional. But there is still an important role for medical professionals to play. A lot of addiction medicine specialists believe that our nation (and our state) won't really turn the tide with overdose deaths until it becomes everyday medicine for frontline clinicians to identify patients with opioid use disorder and help them get treatment. The fastest growing type of treatment for opioid use disorder involves prescribing medicine that reduces the craving for opioids to the patient. This approach, which you may have heard, called medication assisted treatment for opioid use disorder or MAT, is remarkably successful. Studies that follow patients receiving medication for opioid use disorder have found that the risk of overdose death in patients who receive MAT is 75% less than patients who do not receive medication. Imagine how much our state could knock down overdose deaths if every patient with opioid use disorder received MAT.

Interview with Dr. Jordan and Dr. Shukla: 2:20
JFB: Getting as many North Carolina patients with opioid use disorder into treatment is in fact a top priority for our state. On this episode of Med Board Matters, I am delighted to welcome two people who have been at the forefront of these efforts. Dr. Robin Jordan is a board-certified psychiatrist and addiction medicine specialist. She's also an assistant professor in the UNC School of Medicine. Dr. Jordan is the medical director of the UNC Addiction Medicine Program and also serves as the program director for the UNC Addiction Medicine Fellowship. Dr. Shuchin Shukla comes at the treatment of addiction from the family medicine side of things. He is a board-certified family physician and is also certified by the American Board of Preventive Medicine in Addiction Medicine. Dr. Shukla is a faculty physician with the Mountain Area Health Education Center in Asheville and an associate clinical professor of Medicine in the Department of Family Medicine at the UNC School of Medicine. Dr. Jordan, Dr. Shukla, welcome. So, I introduced this episode by talking about MAT, medication assisted treatment. But I understand, Dr. Jordan, when I reached out to talk with you about being part of this podcast episode, you educated me by telling me that the term has actually evolved so that it's now medication for opioid use disorder. And I wondered if you could talk about why the change, and you help our listeners understand.

RJ: Sure, absolutely. So, the term medication assisted treatment we've come to see is really not being as accurate. And what its suggesting is that the medications are assisting the treatment and the treatment

is something else. And it puts emphasis on the treatment being more of the therapy options being the priority and medications being second. And what we've known from the data now is that the medications are lifesaving, and the medications absolutely should be offered first. And so, what this shift for people to understand that medications should be prescribed first, and therapy should be adjunct to that. So, the shift in the term was more medications for opioid use disorder, just to remove that stigma from them and just call them what they are medicines for opioid use disorder.

JFB: Okay. Can we use the abbreviation MOD? I think that's one of the things with MAT, that's a silly question, but it does have a nice abbreviation to be able to say, MAT. But that's an excellent point. Could you, either of you talk about why the medication is so important? I mean, I know it's lifesaving and it has so many different positive effects, but I wonder if you could talk about some of those for our listeners.

SS: Sure, I can field that. And I will say that with this shift to MOUD, medication for opioid use disorder, I think there was an acknowledgment that MAT is just a really good three good letters. And so, I've heard the phrase medication for addiction treatment, which is thereby like sort of emphasizing that that medication is the treatment for addiction and then you can still keep your MAT. But anyway, that's just for fun, fun, fun, fun times. Yeah. So, you know, treatment for substance use and particularly opioid use disorder has historically not followed a strong scientific basis in terms of American policy. Right? We've had a criminal justice law and order approach for several decades now. But when you look at it from the science background and you compare it to any other medical treatment we do, whether it's for diabetes or high blood pressure, you do some basic science, which is you have one group that gets the treatment, in this case, buprenorphine or methadone, are the two primary FDA approved medications. And you have another group that gets what we might say, usual care and usual care oftentimes in the U.S. is an abstinence-based approach, meaning counseling and therapy in groups, which is very useful for a lot of different mental health conditions. But unless you do the research, you won't know how effective it is for preventing overdose and other adverse effects from an opioid use disorder. And so time and again, in numerous studies over many years, the group that gets buprenorphine has much better outcomes in terms of being alive, not developing HIV or Hep C infections, not having ongoing substance use. And, you know, on down the line, criminal justice involvement, endocarditis, heart valve infections, etc., A much greater reduction in the group getting the treatments, the medication compared to the group, getting counseling therapy groups. And that remain the same effect even if folks did really, as I say in my lectures, if they went to like the celebrity addiction treatment that, you know, they had these TV shows on where you go and, you know, you ride horses and eat gourmet meals and do really high quality, you know, for sure, high quality counseling versus, you know, what is the more traditional abstinence based approach in the U.S., which is getting incarcerated and being forced to withdraw. No matter what of those types of abstinence-based approaches you do, you generally do pretty poorly. And the general fact figure is about one out of ten people are doing well on that abstinence-based approach as opposed to folks getting buprenorphine or methadone. One out of two are doing well over a 6-to-12-month period when they get the medication.

JFB: Wow. That is a huge difference. Thank you, Dr. Shukla, for that. I wonder, could we talk just to sort of broad brush about the work that you all have been involved in, in trying to expand access to

medication for patients with addiction? A lot of that, I understand, has been focused on training more clinicians in our state to provide it to be able to prescribe buprenorphine.

RJ: Sure, so with addiction medicine, I think there's two layers here for providers. So, there is the addiction medicine specialty, which became a broad recognized specialty a few years ago. And there's definitely have three addiction medicine fellowships and one Addiction Psychiatry Fellowship in North Carolina. And so, people who really want to specialize in addiction medicine have opportunities to train in this. I think what sometimes gets misunderstood is that to treat addiction, you must be an addiction specialist, which is absolutely not the case. So, we have to treat addiction as a specialty, just like we treat any other specialty. And so, addiction should be treated in primary care. And whenever the primary care needs a little extra help, then they can reach out to the addiction specialist and so that is what we've really been focusing on… on the last few years, is how do we integrate addiction medicine into primary care and make sure that our primary care providers are really filling comfortable and confident and providing basic addiction medicine, and then that they have good relationships with the addiction specialist when they need it. And so, they can either reach out to the specialists if they've got questions, or they can refer to the specialist if they need more help than that.

JFB: Thank you, Dr. Jordan. Now, traditionally, clinicians have had to be waivered, have had to do some training and get approved before they could lawfully prescribe buprenorphine. And one of the focuses of work in North Carolina has been to get more people trained and waivered so that they can prescribe the medication. Talk to me about how successful has our state been at training more providers to prescribe?

SS: Right. So, there's multiple programs have been going on for years now, funded through the state and then sometimes through foundations. So, one is may has been funded through MAHEC is to focus on training medical residents, physician assistant students and nurse practitioner students in their respective schools and that's really with the idea that we need to create a pipeline for, as Dr. Jordan mentioned, primary care providers to provide that level of service. And so certainly the residency project, as we call it, focused on primary care fields, family medicine, internal medicine, pediatrics, OB-GYN. We also brought that training to surgery residents, and I think urology residents and a few other programs, because addiction is absolutely touching all aspects of health, wellness, even public life for anyone who's walk through any downtown of any city in America. And really and just emphasize Dr. Jordan's point, man, I do want my patients to get the best possible care. And if we had hundreds of thousands of psych, addiction psychiatrists in America, I would want my patients to see them. But there's no way we can develop that pipeline to meet the rapidity of the increase in overdose. Even if you created through tons of money, you create a lot of addiction medicine, addiction psychiatry programs, the years of training to get those folks to the point of delivering that care would not keep pace with how fast the overdose crisis has worsened. And so, there's a need to quicken that pipeline, and to really emphasize, as Dr. Jordan mentioned, primary care providers of all stripes and locales to be able to provide that service. So, that's sort of the one element, the future workforce. So, like, you know, I think the first year MAHEC did this program was in 2018, I think. So those are folks who have graduated and are working, you know, for probably years now and maybe a certain percentage of those individuals that got trained, the waiver training, as it was called back then, are prescribing buprenorphine. And so that's great. As we know, a lot of folks that graduate from, let's say, North Carolina residency programs are

more likely to continue their medical career in that same state that they were trained. And then the work that Dr. Jordan and I were so pleased to work together do over these past two years, is focused on the current workforce, which, you know, the current workforce, the average provider in clinics that serve high risk population, they're very pushed to take care of a lot of different patients with a lot of complex needs, especially in a state like ours that's not expanded Medicaid. And so, to add more training on to their plate was a different beast compared to medical residencies. Students who are in like learning and and growing mode. And so, it was a different set of work of how to engage folks who are feeling the pressure of, oh, how do I take care of this problem when I have to take care of their diabetes, their high blood pressure, their mental health issues? And so there's a different level of engagement, those folks. But we've reached 15 over a course of two years, 15 mostly federally qualified health centers and in a few rural areas, health departments to really focus on areas of the state that either had high rates of overdose, low rates of…of capacity for treatments or otherwise were really ripe for our services and supports, expand or initiate those treatment resources. And so that's been the broader scope of things. And then the future or as we're writing it now and Dr. Jordan leading this effort, so I won't take her thunder, is to really build on the first 15 network of what we eventually have been calling spokes in our hub and spoke model to really create a pipeline not only for patients to move around because patients do move around, but also to create, you know, partnerships in terms of mentorship for providers who have less experience with providers, who have more experience with health systems, that have more infrastructure to partner with rural health systems or rural clinic, have less of that treatment infrastructure, and really have a state level approach to treatment capacity for something that's so treatable. Really.

JFB: That's great. Well, thank you for that. I wanted to pause and talk a little bit about efforts to train established working clinicians in the state. And one thing that I know that there's been efforts, you know, courses that are just offered to the general licensed population for physicians, PAs and NPs. And many people have completed that training. Many people have even obtained the waiver to prescribe. But I have heard addiction medicine specialists note that the prescribing of buprenorphine has not necessarily risen at the same rate as then the percentage of waivers has increased. So, what that tells us, of course, is that getting the waiver that says you're qualified to prescribe buprenorphine isn't necessarily getting people over the hump where they're then actively treating. And I think you've just, you know, forecast you know, the reason why is because the support, you know, they're not quite there yet with the comfort level. And then also I think a secondary thing is stigma, you know, the persistent stigma that surrounds people with addiction and what it means to treat addiction in your practice. And I wondered maybe, Dr. Jordan, could you talk about the role of stigma and how that is a barrier for people who have taken this really important step of training to provide treatment, and yet they're still not quite comfortable.

RJ: So, going back a second to the waiver part that you brought up where there's more people waivered than there are people prescribing some of that, I personally don't necessarily think it's a bad thing because for years now we've really been advocating for our trainees to get waivered, whether they intend to prescribe or not. And at a minimum, everyone should have the training at a minimum. And so, we've really been pushing people to do that. And now with our medical schools, four out of our five North Carolina medical schools are providing the waiver training as part of their medical school curriculum. So, we're about to have a whole lot of physicians out there with the ability to prescribe

buprenorphine who may or may not choose to. But I think the idea here is that this really should be a part of general medical education, and we're playing catch up with our current workforce. So, it's okay that we've got a lot of people waivered who may not be prescribing because we're at least getting people educated. So that's a good first step. But then how do we get them from that point of being educated about it to prescribing and feeling confident in their practice? And so that's where we really, really focus over the last few years is what is really needed. And we were talking about the current workforce, it is difficult as doctors are brought up as the barriers that people are facing of so many pressures with their general workday and how do they integrate into something new? It's always something new that they've got to take on and got to learn it. So, it really does take quite a bit of time and effort to make sure that we're providing the support that they need to be able to do this. And there is a lot of stigma within the clinic. So, a provider might reach out and say, I want to do this, but there's no way that my clinic is ever going to agree to it. And so that's not an unusual thing for us to hear. And so, then it's a conversation with the clinic and with the organization and where is their mindset and what do they what are their goals and what are the challenges that they're seeing from addiction in their community? And how can we be supportive in those ways, so that the training that MAHEC offers are a fantastic way to help the clinics get up to speed on just some basics for their non provider staff to learn about the patients that they'll treat. But we've also found that the mentorship, the direct one on one relationships are vital for getting people to go from that step of knowledge to prescribing. So, there's just something about having that person that you can call and say, okay, I'm going to write my first prescription and just, you know, just have somebody with you say you can do this. Let's do it together. And that to me, it seems to be what is the thing that pushes people over to say, okay, I can do this? And usually after they've treated one or two patients, they say, hey, this is easy. I got this. And it's a good confidence boost because they see people get better so fast. So, it's just that initial getting over that fear. Then they realize they have the skills that they need to be able to do this. So, speaking to the stigma, we still have stigma out there of I don't want those patients in my clinic, we'd have to have a separate building for those patients. These kinds of stigmas are still out there. And the reality is those patients are North Carolina citizens who are already in your practices and so is recognizing that it's not a separate population of people, it's the people you're already treating and is recognizing while these people that you're treating have substance use disorders or family members with substance use disorders. And it's just a matter of talking with your patients to see what their needs are.

JFB: Absolutely. I think that is so important. We do a lot of customer service at the medical board. And one of the common things we hear from patients is that if their provider suspects that they are addicted to opioids, one thing that can happen is that they'll just be released as a patient. They'll say, you know, I'm not going to prescribe for you anymore and I can't take care of you anymore. And then they're out with no medical care, still with the opioid use problem. And I think obviously that is not an ideal approach to exclude someone from care because they have an addiction. What are your thoughts on steps that clinicians can take to get to the point where they're able to identify addiction, intervene and then refer? The stigma is obviously a big part of that, you know, getting to the point where they're comfortable. But I just feel that such a critical step, you know, is getting to the point where instead of booting the patient out of your practice, which I guess from an efficiency standpoint, true, they're not your problem anymore, but they're not getting the help that they need, which is what, you know, I think our state really wants is for people with addiction to get help.

SS: Yeah, I can start with that because so as a primary care doctor, the answer on the test is you screen folks with the most useful screening tool, which, you know, there's a few, but sort of the consensus is there's a basically a one sentence question that is in the past 12 months, have you used any illicit substances or medications that were not prescribed to you? And that has been shown to have for the amount of energy of asking that one question has some of the best sensitivity and specificity of identifying someone at risk for a substance use disorder. We do know from relatively recent data that a whole lot of Americans use substances and do not develop a use disorder, which is, you know, the medical way of saying addiction, meaning you have a lack of control over use of that substance and or you have negative consequences. So, at first I say that even if someone says, yes, that screening question, that doesn't necessarily mean that they have a use disorder. But, you know, if you get a yest to the question, then you need to investigate further. But I would also say that when you think of this problem of overdose and addiction at the individual provider level, individual patient to provider relationship, individual clinic level, it's a pretty easy disease process to treat. The medications super effective. The dosing is not very complicated. The monitoring isn't very complicated. The medical decision making isn't the hard part. The hard part is that we've criminalized this medical problem. So, tobacco actually causes a lot more deaths per year of Americans than opioids, and yet it's not illegal. And so, if I were to ask someone, hey, do you smoke? They probably wouldn't hesitate to tell me whether they do or do not. But for most patients, they answer that question, do you…have you used illicit substances in the past twelve months? Depending on who's asking the question, they may end up getting treatment. They may end up getting ignored, they may end up being stigmatized, or they may end up in jail or losing their children. So, I would say at the individual clinic level, yeah, the answer on the test is ask the question and that's the most appropriate way to do it and create an environment in your clinic, meaning from the front desk to the back desk where people do not feel that stigma. And so that's, as Dr. Jordan mentioned, the level of training we do is not just at the individual provider of how to prescribe this medication, but it's really a clinic-based approach. The problem in America and in North Carolina is this is a public health problem. And so, I personally think identifying people at risk for a substance use disorder and that risk for overdose should and can happen at the clinic level. But we need to go to where the patients are going now. And in a system where that medical problem is criminalized, we need to find those patients in the criminal justice system and in emergency rooms because that is where they go, since they are basically afraid to get care. And the usual sources of care that people get when they have non criminalize medical problems. And so, I see that work happening in North Carolina and that's a really good thing. I see funding going towards jails and prisons and emergency rooms and hospitals to better integrate with the outpatient setting. But when I talk to sheriffs and jail administrators they say, well, if I give someone buprenorphine in jail, where are they going to get care in the clinic? And so, I think it's really important for outpatient providers, primary care providers, to develop that treatment capacity and not say, well, I can't identify people who need that treatment. They need a partner with their…their allies in that county, in that state, in that locale and that city, and say, hey, you guys are getting the patients at the E.R., at the jail. I can treat those people. Let's work as a coalition. And I'm seeing this more and more at the county level, at the state level. But that's the approach that's needed throughout America and certainly throughout North Carolina of a public health approach of just it can't be on one provider to identify folks and save lives. Really, they're the ones to prescribe and treat and they need to be able to do that, but they have to work with their partners.

JFB: Thank you, Dr. Shukla. It seems like this would be a great time to start talking about the hub and spoke approach and the networks that you've been involved in building. But I do want to pause and ask if there is another screening method that the primary care frontline clinicians can use that maybe doesn't provoke such fear. I mean, I think you're absolutely right. You know, patients are going to be fearful and they're probably not going to be truthful if they're afraid. Is there a better way than just asking that question straight out? Are you using illicit substances?

RJ: The National Institute on Drug Abuse recommends that (NIDA) has a quick screen, which is the two questions screen in that question that Dr. Shukla mentioned is one of those questions. I think also comes down to how is being asked, because so many times, all of us, we go to the doctor and you don't have suicidal thoughts, right? You don't use drugs, right? So, I think so many times it comes down to how are the questions asked. And I think language is so, so critical and that we really have to think about the language that we use when discussing substance use disorders, because the language we use and practical beliefs that we have. And I want to, if it's okay, I want to go back to a point that you were bringing up earlier about the patients who are prescribed opioids. And then the physician might suspect that we have a use disorder and so they stop their prescribing, which we know is not beneficial for that patient. And I think this comes back to our language. And if we could shift our language, we might be able to shift our beliefs. If we really believe that addiction is a chronic illness, which I do, I believe use disorders, once you have a use disorder that is a chronic disease. Then I think it shifts how we view the pain contract or opioid contract, so people use in primary care. So rather than these contracts of you will be punished if this or this will be terminated, and the contract should look really punitive as opposed to you will be asked to provide urine samples. You know, you may have this. This may occur rather than this will occur, or this will be terminated. And then thinking of things like there are side effects from prescribing opioids and one of the side effects is developing an opioid use disorder and having an open discussion with the patient as a side effect from this medication is development of dependance and development of an opioid use disorder. Here's the symptoms of an opioid use disorder. When we see each other, we'll be monitoring you for development of an opioid use disorder. And it's okay if it happens. It's a side effect of this medication. If you develop signs of a use disorder, will either treat you here on our program or we'll refer you to someone who can manage your opioid use disorder. So, I think shifting the language really can shift how people are looking at this. It's not a punitive thing that someone develops a use disorder.

JFB: Yes. Thank you for mentioning that. I think we have a lot of work to do in making that shift based on the calls that we receive at the medical board. There's a lot of clinics that prescribe opioids that seem to have a sort of zero tolerance policy where you violate your agreement, you're out. So, thank you for returning to that. I'm excited to learn more, though, about the referral network that you are building here in the state. So, who wants to take the first pass at kind of setting out the vision of what you're building?

RJ: So, the network is the North Carolina Substance Treatment and Recovery Network, so the NC Star Network. And so, we've been working on this hub and spoke model for a few years now. And then MAHEC and UNC partnered a couple of years ago, and now ECU is partnering with us. And so, we've gotten additional sponsorship from our state to help us build out this network. And so, it's based on a hub and spoke model where we now have three hubs. One being UNC, one being ECU, and one being

MAHEC, where our hubs can provide an addiction specialist and they can provide the higher acuity treatment needs for those with addiction. And the hubs can also provide the training and support needs. So, then we have the spokes who are the community providers who are interested in treating patients with addiction. And so, we have a referral network set up between us where if the spokes need to refer patients to the hub, they let us know. And if the acuity is too high to be maintained at the stroke, we would treat them at the hub. But also, the other way around. We get a lot of patients at the hub and need a place to send them. So, there's the reciprocal that when our patients are stabilized that we can send them to their spokes where they can go for ongoing maintenance treatment. So really to make the process work, we have to have good relationships between our hubs and spokes, which we've developed over the years. And we've got to make sure that we've got good training. We really focus on dissemination of best practice to make sure that our spokes are also up to date on evidence-based practices, because we've really shifted our practice shifted a lot over the last few years. So, we want to make sure that everybody is up to date on that and low barrier care. And so, we do our best to support the spokes so that they are able to provide addiction treatment.

JFB: Right. Anything to add, Dr. Shukla, about that approach?

SS: Yeah, at least a preview for what Dr. Jordan and I and the rest of our team has envisioned for the future is to think of this hub and spokes as not only the outpatient providers, which, you know, it's a mix of specialists, often in the hub and spokes, often more primary care. But to think of this as again, go back to my public health approach, to think of things like jails and prisons as spokes in that system, as places people both can initiate treatment, but maybe they're getting treatment already and have criminal justice involvement so they can have a continuation of that medication with almost live support for those clinicians in those different settings, including ERs and hospitals in that network, including our state funded detox and rehab units. Because we know that detox and rehab are often thought of as, wow, that's the gold standard treatment. But the evidence actually shows that people at risk of overdose is very, very high after leaving those settings. And so having them network with outpatient providers is critically important for the patients they serve. And I mean I…we can keep going outside the box and think of like when you look at the prevention world, including things like DSS services and even schools in that network, to make sure that education prevention activities are integrated in the spectrum of care and absolutely including things like harm reduction organizations, syringe service organizations and peer support networks in that network will both help bring in patients at higher risk, create a full spectrum of care services for folks at different levels of need, and make sure people don't fall through the cracks. Because, you know, just reflecting on what our state's done and, you know, to even take some credit, that Dr. Jordan and I have done over the past years, there's been an increase in buprenorphine providers when you look at state data. There's been an increase in prescriptions. And yet if you look at that line, it has not had the same curve or same angle as the increase in overdose visits in ERs and overdose events that EMS responds to. So, we need to grow faster than the problem is growing, which we have not been able to do despite our best efforts. And really, again, that's focused on folks at the highest risk, folks of folks who are unhoused, folks without insurance, folks in rural areas, pregnant, parenting women. And then increasingly as shown in the recent CDC MMWR data, people of color are having a higher than that other population increase in overdose past years. And so, we really need to be proactive and engage in the levels of care as well as the sites of where those high-risk groups are finding themselves.

JFB: Okay. Now, how do people who want to be a spoke, you know, get connected to a hub? And how does somebody who is saying this all sounds good. You know, I would be willing to treat addiction in my practice if I knew I had that support and I could easily reach out to a specialist if it was necessary, if I had questions, etc. So, what information can you provide to people who are in that position, who want to get connected and who are may need to reach out?

RJ: So right now, the easiest way is to reach out to Dr. Shukla or to me. People at MAHEC or at UNC. I think we're both pretty reachable. People reach out to us a lot. So, I think the easiest thing is just email us, let us know you're interested and we will be on it. We'll reach out immediately. We're happy to talk with people who will voice interest.

JFB: Okay. And is there any information that we, the medical board, can provide on our website is the show page so that anybody who listens, if they want to go back and look at resources, we'd love to share anything that you have you know, that would be good for somebody who's just getting started?

RJ: Yes, we can provide that. So, we're still in process of creating these things, but we can provide you what we have for sure.

JFB: Okay, perfect. One thing that I wanted to make sure didn't fall through the cracks is that there was a rule change in the last couple of years with regard to waivering and training requirements. Can we talk about that just briefly? Because I think that is one of the changes that was implemented to try to lower the barrier and to encourage more people to start prescribing buprenorphine.

SS: Yeah. Previously I think this rule change, Dr. Jordan may need to help me. I think it was in 2020, but previously too that MDs and DOs had to do about 8 hours of training through a few accredited sources on how to manage opioid use disorder and prescribe buprenorphine specifically. But they also talked about some of the other treatment modalities. And then for nurse practitioners and physician assistants and midwives, it was 24 hours and I was just again, I'm beating a dead horse. I probably hear some of you people are sick of hearing it, but the folks who are dying the most are the folks who are at highest risk. And those folks often engage in levels of service at things like FQ and season eight health departments and in rural areas where, you know, those clinics are mostly staffed with nurse practitioners and physician assistants. And so, as you can imagine, that was a tremendous barrier to get access to care and the places people needed it most in this country and in the state. So the rule change now since 2020 was that that training is not required in order to prescribe for up to 30 patients, buprenorphine. But you still have to register with the DEA and with SAMHSA. It is free if you already have a normal DEA number to get your, as we call it, the XDEA number. There's no extra cost. And and folks can certainly reach out to our team at MAHEC on how to walk through that. But it's sort of a step-by-step process of going on the SAMHSA website. I would emphasize that the training is useful. I think most people that do the training and that's just the waiver training, let alone all the other trainings we do about segment bias, about equity and how to train the front desk on how to talk to patients and how you know how to handle labs. The wraparound trainings are useful, but at the very least the waiver training is useful for providers. And so I wouldn't want to diminish that. Oh, now you can do this and you know, do it without any training. But that being said, you know, folks prescribe insulin and they do get training and residency. I would hope most people do. But insulin is terribly dangerous. If you take too much, you will have a at times fatal outcome. And buprenorphine is not like that. And so, the training is

useful to take good care of patients, but you don't need it to get your waiver and you don't need it to take good care of patients. If you get other sources of training to go over 30 patients, you do need to do the formal either 8 hours or 24 hours and and then register that training credential with SAMHSA to go above 30 patients at any given time. But the average primary care provider, even if they're doing high level work with this, but doing it in the context of primary care, OB-GYN care, pediatric care, what have you, they probably won't need to go over 30. And so, I wouldn't want folks to think like, oh, man, what if I hit 30? Like, that's not going to be a problem if folks just did that level. If even 50% or even 20% of primary care docs in the world or in the country, did that level care? We would have a tremendous increase in capacity.

JFB: And I know now that I think about it, that I believe MAHEC actually even did a webinar about getting started aimed at people who did not do the eight hour training.

SS: Sure. And Dr. Jordan's also done those trainings. That's something we've done over these years of just whether informal, small group meetings or the formal waiver training or a shortened version of that. I mean, we're trying to find any way to reduce that, you know, of the many barriers of people having this life saving treatment, the one barrier providers feeling they had the training, we've done our darndest to address that barrier and make good progress. And I'd say, you know, when I think of treatment for patients, right, there's, you know, folks who need a lot and want a lot and there's folks who want less. And we often see that's either low barrier treatment access or even on the harm reduction approach to things. I think of the same thing with clinics and clinicians, if that's a weird thing to say out loud in that some folks may want to like easier way to do this without going through some formal training or engaging in some hub and spokes. And so, UNC and MAHEC had both offer Project Echo, which is free and easy to log in and log off and you can do it while you're eating breakfast or dressing your kids in the morning and that's available on our websites and we can make sure that's available to your listeners. So, there's a lot of ways to start wading into the waters of like, hey, is this something I want to do? But I think, yeah, what we're building with our hub and spokes is that hand to hand or a warm handoff kind of connection of training and feeling like you can build a program in your clinic no matter if you're in urban or rural or solo practice or a big group practice.

JFB: Right. That is that all the prepared questions I had except for wrapping up with the big picture that the work that you're doing here ultimately is aimed at reducing those opioid overdose deaths. Right. So, I would invite you just to say anything else, any final parting comments that you wanted to add about why you're doing this work and what the ultimate goal is. Dr. Jordan?

RJ: Yeah, so this work is incredibly meaningful, and I feel so just fortunate that I get to participate in this work. So many of us went into medicine because we want to help people, because we want to make lives better for people. And so many aspects of medicine, that's kind of difficult to feel that that you might be having that impact. And what people don't realize, people will say, Oh, bless you for doing this work. And they don't realize that this work is so incredibly meaningful. That in just a matter of weeks I can work with a patient and they invite me into their lives and they invite me on this journey with them and I get to watch their life change. They go from the lowest point of their life, and I get to watch them get better. I get to watch them engage with their children, sometimes get their children returned to them. I watch them return to employment. I watch them build relationships with their families, get

housing, all the things that we wanted when we went into medicine to see people's lives get better. I get to have a hand in that, and I just don't think there's another place in medicine where you get to do that. So, it's not like we're special people to do this work. We actually found the key, finding a really fun way in medicine to really help people. So, anybody who's questioning and are thinking that is difficult. What I say is give it a try or at least talk to people who are doing it because it is a really, really amazing way to add meaning into your work.

JFB: I am so glad you said that because that is absolutely true. I sometimes think like how difficult would it be to be an oncologist where there are some patients you just can't help, you know, or palliative care? We have a board member who's hospice and palliative care. I mean, those are folks who are at the end of life usually. And you're just trying to make them comfortable. So, I think that's a great point that you get to see the success stories and obviously it's not 100% of the patients that you treat, but that is wonderful. That's…that's pretty inspiring, actually. Dr. Shukla, any parting words from you?

SS: Yeah, I would just echo what Dr. Jordan said, that I've, you know, been a family doctor for over ten years now. And so, you know, I do diabetes and high blood pressure, and I also do HIV care and hepatitis C treatment care. And there's nothing that's more gratifying and like just clinically effective than providing buprenorphine to patients. And as Dr. Jordan said, as a family doc, I look at a family unit. So it's not only like is this person not dying, not going to the ER, but are they able to have meaning in their life? Are they happier? Is their quality of life improved? How are their kids quality of life and their mama and daddy and all the other people in their orbit and their community? All that's really important to me in all that I see get better. It's and it happens in real time, like within especially the first few weeks of getting on treatment. Within a few weeks you can just see the color change in people's, you know, the whites of their eyes and in their in their face and then their demeanor and their ability to engage. And, you know, I don't want to oversell it, but it's hard not to because, you know, just to put it's a back to some statistical level, you know, I think most primary care doctors are very educated about primary prevention of cardiovascular disease with statins. Right. And so, you give people a cholesterol medicine because their cholesterol is high. And the idea is it reduces risk of heart attacks and strokes. The number needed to treat for that, which your listeners should be familiar with, is 120, 120 people over ten years. And you save one heart attack. With buprenorphine, it's two. You treat two people. And over a 12-month period, one of those people is doing really well. And if you look at mortality benefit in terms of reducing risk of death, it's less than two. I mean, it's close to one. It's that effective. And so, you have a very effective medicine that changes people's lives in their family and communities. Lives in front of your eyes, man. I feel like, you know, this is doctor Jordan's and I stump speech when we talk to providers to get them interested in this and people are motivated by hearing these words. So, I'm hoping your listeners all feel the same.

JFB: Oh, I agree. And I hope so, too. Thank you so much, both of you, for your time. This is great. I think it's just so important to educate people about this work. And sometimes when you think about opioid overdose, it seems like such a huge problem. It seems hopeless. And to hear you both talk about this work; it really shouldn't be. You know, if we can get people access to treatment, there's tremendous hope. And I think that's a very powerful message. So, thank you both for participating in this episode. I really am grateful.

RJ: Thank you for drawing attention to this as well. Such an important topic and I appreciate you emphasizing it.

JFB: Of course.

Episode closing: 40:20

Well, that brings us to the end of this episode of MedBoard Matters. I know we covered a lot of ground. I hope you learned a thing or two and maybe can move on with your day feeling just a little more hopeful about efforts to combat opioid overdose. Maybe you are even inspired to learn more. If you are, check out our show page at www.ncmedboard.org/podcast. You'll find contact information for Dr. Jordan and Dr. Shukla and links to all sorts of information about medication for addiction treatment. As always, we welcome your thoughts, suggestions and constructive criticisms at podcast@ncmedboard.org. Drop us a line. Jean Fisher Brinkley for MedBoard Matters. Thanks for listening.