Episode 30 – The Mainstreaming of MAT

Intro music: 0:00

Podcast introduction: 0:10
Once upon a time it was a bit of a process to prescribe medication for opioid use disorder. To write buprenorphine – the favored drug for office-based addiction treatment – a medical professional had to clock up to 24 hours of specialized training. Then they had to get a federal waiver. Then for a time, it was even necessary for prescribers to register at the state level. And, perhaps not surprisingly, relatively few clinicians in North Carolina went to the trouble. As a result, the number of medical professionals who treat opioid use disorder with medication has remained far, far lower than the demand for treatment. Increasing patient access to medication for addiction treatment – MAT for short – is a pillar of North Carolina's state Opioid Action Plan. This is Jean Fisher Brinkley, Communications Director for the North Carolina Medical Board, and this is MedBoard Matters. The good news for patients with opioid use disorder is that, relatively recently, Uncle Sam has loosened up when it comes to MAT. In fact, as of December 2022, the hoops for clinicians who want to provide MAT to their patients have been rolled back to the point that, now, anyone with a valid DEA registration can prescribe buprenorphine. On this episode we are taking a look at the current landscape for MAT prescribing. I have asked one of the state's most active advocates for MAT, Dr. Blake Fagan, to help navigate this shifting ground. Dr. Fagan is Department Chair of Family Medicine for MAHEC, the Mountain Area Health Education Center. His main area of interest when teaching, practicing or advocating is the treatment of opioid use disorders. Before we get to it, heads up: The Feds haven't completely done away with training requirements for MAT. There's a new training mandate on the horizon that impacts anyone with an active DEA registration.

Interview with Dr. Blake Fagan: 2:08
JFB: Well, Dr. Fagan, thank you so much for joining me today. I really appreciate it.

BF: Thank you for having me.

JFB: Now, I have introduced you as one of the state's most enthusiastic supporters and advocates for MAT. But I know that that was not always the case. And I wondered if you'd begin by just sort of telling your own personal story of how you first learned about MAT and how you came to be such an enthusiastic supporter.

BF: Yeah, thanks for giving me that opportunity. So back in probably around 2011, like you said, I had actually never heard of the word buprenorphine. I'm sad to say, I probably was taught that at some point in maybe medical school or residency or after, but I sure don't remember it. And if somebody would have come to me and said, you should write this medication to help people that have opioid use disorder, or back then probably would have said to help people that have opioid addiction, I would have said, no way, you're just substituting one addiction for another. I'm not going to do that. But in 2011, I had a patient of mine who rolled into the emergency department dead from an overdose. I had actually delivered her two kids and it was just devastating for me. And I remember talking to the emergency room doctor and was like, what happened? And the emergency room physician saying, duh, there's an

opioid crisis. Where have you been? And I don't know where I'd been, but that's when I started reading more about opioid use disorder and finding out about buprenorphine and then proposing it to my organization, the Mountain Area Health Education Center, that, hey, we should be prescribing this for patients that have opioid use disorder, and we should be actually teaching the next generation of prescribers like our residents. I'm in a residency program, so like our residents in family medicine and OB and psychiatry and internal medicine to prescribe this medication along with teaching it to our medical students. So that started my journey.

JFB: Thank you for sharing that. That is such a powerful story, and I think it meets where some of our licensees probably are with this topic. I think that, you know, there probably are quite a few of our licensees who still think that prescribing buprenorphine is substituting one drug for another. My own non clinician experience has been that the more people learn about MAT and buprenorphine prescribing specifically, the less you tend to see that attitude. So, the reason that, you know, we wanted to talk more about MAT now, of course, is because the federal government had recently changed the rules for prescribing once again. And it's been sort of moving ground in recent years. Let's talk about sort of how things used to be. You know, what the rules used to be and then where things have evolved to as of I believe it was December 2022.

BF: Great. So, it used to be a long time ago, 1973, I believe that there was only one medication that was really available for people that had an opioid use disorder, and it was methadone, and it could only be prescribed in methadone clinics is what they called them back then, but they call them opioid treatment programs now. And then in 2000, there was part of a law that was passed that allowed buprenorphine to be written as well, but you had to do some training if you were an MD or a DO. So, you had to do 8 hours of training and then you could get your DATA 2000 license. But the 2000 is because it was passed in this law in 2000. Some people called it the X waiver, others called it your buprenorphine license. They all mean the same thing. And then at that time, nurse practitioners, physician assistants and certified nurse midwives could not write the medicine. And there was very few people that went about getting the 8 hours of training to be able to prescribe this medication, which now we know is can be quite life saving for folks that have opiate used disorder. And then in 2016, they did pass a law that said that nurse practitioners, physician assistants and certified nurse midwives could also do extra training and get their X waiver or their buprenorphine license. And they had to do 24 hours. And both of the 8 hours of training in that 24 hours of training were based on actually no data and were found to be quite a barrier in the medical community to writing the medicine, meaning many people that were ambivalent, let's say, about the medicine could say like, hey, I don't have my license, so I can't write this medication. And then at the end of 2022, December 2022, the MAT Act and the…the so the MAT and the MATE Act passed and now there's no requirement to get an X waiver or to sign up or to do any things that were a barrier under the MAT Act. Now anybody that has a free and clear DEA license is allowed to write buprenorphine. I say like lisinopril, but maybe even a better analogy since it is a schedule three drug is like Ritalin or Adderall. So, when you do, then you have to send it in with a code through your HER. But there's no number. Also, this is another thing that happened. Back with the DATA 2000 law that passed is that initially you could only write for 30 people, and then after a year, you could petition to go up to 100. But that's no longer the case either. So, you don't have to have an X waiver. You write it just like

any other thing, like hydrocodone, like Ritalin. And then there's not a number of patients that you can write it for. You can write it for one or 100 or 200.

JFB: Okay, great. Well, thank you for that summary. I have kind of a two part follow up question. First, let's talk about the intent. You know what…why do you think that the federal government went to this next step? No waiver, no limit on patients treated?

BF: I think the intent was to knock down barriers so that any patient that discloses that they have a use disorder to any provider can get immediate help. A patient could be in the emergency department and disclose they have a use disorder or maybe have overdosed, and they've given Narcan and been revived and that emergency room provider can give medication. Someone could be in the hospital and then be admitted for let's say, osteomyelitis or discitis or endocarditis. And it comes out in history that they are injecting fentanyl. And that's more than likely the reason that they have this infection. And now anybody on that team, whether it's the hospitalist, the infectious disease doctor or anybody else, could start buprenorphine and help at discharge for that person to get connected to outside services. And that's the same as all the primary care folks, whether you're in a private practice or in a big group setting or in a federally qualified health center. Whether you're a nurse practitioner or a PA or a physician, you can now write the medication. So, it's really broken down that barrier to where we all can be a part of this disease, which I believe is a chronic disease. It's up there with high blood pressure, diabetes, asthma, and it's very pervasive. So, we need to get comfortable with screening for substance use disorders, particularly opioid use disorder and then diagnosis and treatment. And this medication is one that we all can right.

JFB: Now, the second part of this and you sort of alluded to it when you mention the MATE Act, the federal government, on the one hand, they're knocking down barriers. On the other hand, the federal government's not exactly saying you don't need any training, you know, you don't need any education to do this. Is that correct?

BF: That's right. The MATE M-A-T-E Act that past December again of 2022, it said that if you have an active DEA license, you will need to do 8 hours of training. It looks like what they're saying now is that it's one time. So, if you did the 8 hours of buprenorphine training through, let's say, SAMHSA or ASAM, anything online that counts and you're good, you're done. If you did 3 hours of training in your state, like in North Carolina, we do 3 hours training every three years around opioids. They're saying that those 3 hours are going to count. You need to find five more hours. But it sounds like it's a one-time thing. They want people that have a DEA license. So even if you're a radiologist, pathologist, cardiologist, but of course, if you're a primary care provider or emergency room doctor or a hospitalist, they're saying you have to do these 8 hours and there's going to be lots of things that count is what they're telling us. And lots of organizations are now trying to organize around how to best teach about buprenorphine so that people can be comfortable at multiple levels. One level might be just screening and diagnosis and getting one day or three days of the medication and then getting them to another provider that takes over and that's fine. And there's will be others that will want to go a little bit deeper and do some of that continuing professional development or continuing medical education where they learn more about buprenorphine so that they can prescribe it for folks long term.

JFB: Right. So just to make sure our listeners fully understand what this requirement says, it is a new one-time requirement to complete 8 hours of training that covers the topic specifically of treatment and management of patients with opioid use disorder or other substance use disorder. But certainly, probably opioid use is top of mind.

BF: I believe that's true, that information from the federal government at this time still coming out or evolving. So, everything you said I think is true. And I think if you do some training around opioids and how to prescribe those correctly, either for acute pain or chronic pain, that they're telling us that that's going to count as well.

JFB: Gotcha. Okay. I did just want to put a bug in the ear of anyone who this directly applies to among our listeners that this is something that they need to sort out and figure out how they're going to satisfy this requirement by really the end of June of this year. So not a lot of time by June 27th. Actually, I just looked up the specific deadline. Anyone with a DEA registration has to be ready to check a box on their DEA registration form that says, yes, I've done this, I've completed my new 8 hours of training. So, let's talk about some of the opportunities. I feel pretty certain that our licenses are going to be happy to know that they can satisfy this requirement with training they've already completed. That's a huge help, obviously, to prescribers to be able to use prior continuing medical education that covered these topics. If you still need hours, let's talk about some of the opportunities for training that exist. You know, and feel free to certainly start with talking about things that MAHEC is working on because you are one of the most active centers in the state on this topic.

BF: I think there's several organizations that do continuing medical education that you can log on to in North Carolina. Many of the AHECs area health education centers have online presence, and you can look and find out how to click and take care of some of these hours. So that's a good place to start. Also, SAMHSA, the Substance Abuse Mental Health Services Organization. I hope I said that right. But you can Google that and they have online hours that you can take 4 hours or 8 hours right there. And the last time I checked; it was free. So that's another option. So, but there's I think there's a lot of options out there online.

JFB: MM-Hmm. Okay. I don't mean to make this all about the new requirement, but it is obviously an important one for anyone with a DEA registration, but it doesn't appear that the federal government has put a time limit on it, so let's say you went through an old waiver training for MAT three years ago and you did your 8 hours, are you covered as far as you know?
BF: As far as I know, that's correct. That's what I've heard. So, like in North Carolina, I believe now all five of our medical schools, when you're graduating from there, they are saying that you've completed 8 hours of training around substance use and opiate use disorder. They're telling me that would count even though you still would go through a residency and then get your DEA after, that you could look back and say, hey, I've completed that. If you were in a residency program, which several of them in North Carolina are training around substance use disorders, but particularly around, again, opioid use disorder. If you can show or demonstrate that during your residency that you completed 8 hours, then that's going to count. So, when you get out, you get your DEA and you just say like, hey, I graduated from Residency X and here's my didactics or my 8 hours.

JFB: And that yeah, I mean, that you mentioned earlier that when you were training, you know, this sort of training in prescribing medication for opioid use disorder just really didn't exist. I thought that was interesting, that, you know, the rules about this new training requirement, they anticipate basically that anybody coming out of residency training, that they will have studied this as part of their curriculum, as part of their training, just as a matter of course. So, it's just a comment on how far things have come with our training for physicians and PAs and other prescribers.

BF: Yes, for sure. And all I think is a good thing. There's a lot of competing interests out there. We definitely have to train people on your specialty subspecialty and, you know, diabetes, high blood pressure, other things as well that opioid use disorder is a leading cause of death in our young people. And we all need to be able to recognize signs, symptoms or feel comfortable with screening and then making a diagnosis. And now we all have this medication, buprenorphine, that's very safe. If taken correctly, you don't die and we all can prescribe this medication now, which is great.

JFB: I wonder if you could offer some guidance. You were describing earlier sort of the really powerful potential of buprenorphine. So, someone comes into the E.D. with an overdose diagnosis or with some sort of infection that's related to opioid use. And it sounded like, oh, you know, that's division. When it's built out, you know, everybody's comfortable, everybody's prescribing the medication as intended. But as we know from talking about this and learning about buprenorphine in the last several years, having the training doesn't necessarily mean you're ready to write your first prescription, that you're ready to manage patients. So how would you guide somebody who is willing to answer the challenge, you know, is…is ready to learn more. But they haven't actually previously written buprenorphine for patients. So what does that look like? How do you get up and running?

BF: That's a great question. I think there's two parts to this with quite a bit of overlap, but I'll talk about the individual prescriber and then I'll talk about like a clinic that you might work in. But for the individual prescriber, you have to get some comfort with it. And so, I'm going to encourage you to do some training. You can do it online, you can do it in person, but it's very similar to, let's say, some of the new diabetes medications that come out and you read about it. But what do you do? Well, you talk to your colleagues and ask them what they know about it, how they've used the drug, what they've noticed as benefits of it. And then you might talk to a pharmacist and ask them questions. And then when you finally feel like you have a patient that is ready for this medication, you might reach out before or after you've written it and kind of talk it through with somebody that has a little more experience than you do. And like, this is what I did, and this is how I wrote the buprenorphine. And they're like, that's right, that sounds great. Next time, instead of just giving them one day and seeing them back, because I know you're nervous, you can you know, you can try to give them a few more days or when you see them tomorrow, look for X and Y, and then maybe you can write for a week. And that's how we once you're out of training, that's how many of us learn new medications. As we read about them, we talk about them, and then we finally write it. But we often reflect either with ourselves or with other people about how it went. And then after you do it a second time, a third time, you get that more comfort and you start to feel better or more comfortable about how to write that medicine. And that's how I would do it for an individual.

JFB: Okay. And you mentioned a clinic based.

BF: Yeah. So sometimes with clinics, the same kind of thing has to happen because it's a whole clinic. Let's say it has six people in it that write or...are maybe there's 20 that there may need to be more of a discussion in the group about when are we going to start, what patients are we going to try this with first? Hey, let's to get together after we've all written maybe one prescription. So, at the end of this month, we'll make a goal of trying to find the appropriate patient. We'll write for it, and then let's get together and talk about it. And that meeting may happen for several more months until you've talked about some of the harder cases and everyone's gotten a comfort together about how to do it. But trying to get the clinic up and going and feeling comfortable about it may be that you bring somebody in that talks or actually provides that education, be it one, two or 8 hours, or the clinic pledges as a group to go online and do their training together and then talk about it afterwards and write for the first person. Knowing also that the people around you have to be comfortable. So, have you talked to your nursing staff or your clinic staff? Have you talked to your front desk? Have you talked to administrators and answered their questions? This disease, opioid use disorder, and this medicine, buprenorphine, there's a lot of stigma and bias associated with it. So, I think it's important for groups of people to talk it through, let people in an honest and open forum, say some of their concerns, and then answer those questions so that the team has some comfort. And a lot of what I just said is something that you can also obtain. It's called technical assistance. So, there are people in North Carolina and across the United States that provide technical assistance to stand up clinics, stand up residencies that want to start training their providers in buprenorphine and then start writing.

JFB: Okay, great. I was just going to ask you or make the comment that North Carolina is fortunate that it actually has a pretty well-developed infrastructure to support MAT prescribers. Would you say just a little bit more about where are you most likely as either a clinic or an individual prescriber to find that kind of support and technical assistance if you need it?

BF: You can reach out to the state, The Department of Health and Human Services. Department of Public Health can direct you. The AHEC system, has several folks that do technical assistance, many of them in your area. And so, there are some federal grants and there are some state grants that provide that technical assistance. So, there is a federal grant through SAMHSA. So, you can also go to their website and ask for somebody that will then reach out to you and answer your questions and talk to you again before or after you've written that first prescription.

JFB: Okay, great. Now, we have talked about buprenorphine as a lifesaving medication. Can you just share some stories about what we mean? I mean, I know it's a really powerful drug. It stands out to me because of this whole question around treatment effects. You know, how many patients do you have to treat with a therapy before you see some benefit to society or benefit to…to patients directly? And I was pretty impressed when I heard that buprenorphine has a treatment effect, I think it was two, that you have to treat two patients in order to see some benefit. And I wonder if you could just talk about why this medication has earned such a reputation as a lifesaver on a like changer.

BF: Yeah. Thank you. So, I'll back up to say, like opioids cause brain changes. Not in everyone. The more opioids you take over time, the more likely you are to have brain changes. Again, not in everyone. And then when you're taking opioids in a use disorder, you've had those brain changes now where your brain has been hijacked so that you then start to have cravings and you start having physical withdrawal. And so, people that are in their opioid use disorder, they can intellectually in the frontal lobe tell you, I know this is bad for me. I know I need to stop. And they can say all the right things, but their lizard brain will hijack them when the cravings get so intense, and they will use again. And one of the lifesaving wonderful things about buprenorphine is most people are going to be on between eight milligrams of the buprenorphine and 24 milligrams. And so, if you can get the right dose for someone, you can stop their withdrawal completely and you can drive their cravings down to being mild or maybe even to zero. And when you do that, you will see that about 50% of people will lock into your program. They'll do what you ask of them. And as they take the medicine, you'll see if you were to get urine drug screens, you will see that other opioids, like fentanyl, will just disappear from these urine drug screens because they're like, well, I don't need that anymore. The buprenorphine has stabilized my brain. I'm not having any withdrawal symptoms. My cravings are milder or none or almost none. And with that, it's…it really, truly is amazing to see about one out of two will lock in with you. And that means 50%, though, are not ready and they will wander off or not return to see you. The 50% that sees you though you'll start to see actually a really short amount of time, weeks to months that they start engaging with loved ones, trying to rebuild relationships. They get jobs, they go back to school, they get kids out of foster care. I mean, it's amazing. I've had some patients in front of me in tears just saying, like, this medicine has helped me to get my kids back out of foster care and they're with me now. And that is life changing for them, but also for their kids, as you can imagine. Or if you know anything about a scores, we really do want to help people to stabilize their lives with this med.

JFB: Yeah, no matter how many times I hear people talk about that, it still just gives me chills that there's a treatment that is that effective out there. What are some of the common challenges that newer prescribers experience with prescribing buprenorphine?

BF: Yeah, so I think newer prescribers, there's a discomfort with a new medicine. There's a worry that I'm going to do it wrong. Initially when you're first starting to learn this medication, I'm going to encourage you to write the combo product so that you can feel comfortable that you're writing a medication that's less used incorrectly or diverted so that when I say the combo product, it's buprenorphine / naloxone. So that should give you comfort. I've now told you that most people that have an opioid use disorder are going to be on between eight and 24 milligrams. When you first start to write this medication, never go above 24 milligrams. So, you now have a hard stop at the top. And then when you get through those discomforts of starting someone, you say you've done it once or twice, a couple of things will come up. You may have someone come back in and they have a urine drug screen that it no longer has fentanyl in it. It has buprenorphine, but it has methamphetamines. And then there's going to be this, what do I do? Well, in the harm reduction model, you have helped them to not use fentanyl anymore, which could kill them. And so, you need to work through that in your own mind and with people in your clinic. Recruit behavioral health and either your clinic or your area to help you with this and feel some comfort that you're trying to help folks. But you've extinguished one illicit drug, the fentanyl, let's say, with the buprenorphine. But buprenorphine doesn't stop people from craving or

wanting to use, let's say, methamphetamines or cocaine, THC, other things. That's the next barrier is getting through that hey, for those things to get better, I should keep engaging with this patient, keep them on the buprenorphine because they're not taking fentanyl, but then get them into some behavioral health therapy or get them to some other therapies or therapies that can help with those other use disorders. I think those are some of the really big ones and they're wrapped up in some of those words. Stigma and bias, yeah.

JFB: Yeah. I'm glad you mentioned that because I think, you know, it's not too hard to figure out where this zero-tolerance attitude came from because of course, in the pain prescribing environment, it's pretty common for there to be an attitude that if there are non-prescribed medications in a patient's urine or blood, that you can't continue to prescribe for them. But what you're describing, again, with the harm reduction model, that is not the case. You need to sort of look at the big picture, look at the behavior change that you have achieved and continue working with that person. Keeping them in care is better in the long run than excluding them because of illicit use.

BF: Yeah, that's right. With some of the stigma and bias that comes up, I want to address that one question I kind of mentioned at the beginning of this that, okay, so if you're having the thought I don't know about this, I'm just exchanging one addiction for another, now they're on buprenorphine instead of on fentanyl. I want to say I was there. I had the same thoughts. I had to work through them. It didn't take me a minute or an hour. It took me months to feel comfortable with it. I want to acknowledge like, yeah, it is tough to move from, like you said, when I used to write hydrocodone or oxycodone, if there is one thing in the urine drug screen, whether it was THC or anything else I just said, that's it. You know, you violated the contract, we're out. And now I'm trying to say like, hey, the patient is alive. They keep coming in to see you for the buprenorphine. This is a win for them in society. As they come in to see you, you can continue to engage and talk to them about why they're continuing to use, let's say, meth. What are their triggers? How do you work through that? You know how to do motivational interviewing. So, talk to them about that. And then eventually they're like, okay, so you're saying I need to see behavioral health. I'm ready now to see them. You engage them there. So that's great. But back to that question then, you're just substituting one addiction for another. And I want to say like, think about the patient that is on insulin for type one diabetes and what happens when they stop that insulin pump. They don't do well. Their sugars go up, they might go to a thousand, they might get very sick, they might be in the emergency department or even be admitted to hospital. And honestly, they might die. But nobody would say that they're addicted to insulin. They may say, oh, my gosh, they're dependent on insulin. When they're on their insulin pump, they can do life. They can if they're a kid, they can play soccer, they can go to school, they can study. But when they're not on their insulin pump, it's life threatening for them. And that's called dependance. And if you believe that opioids cause brain changes and they do in some and when that happens, you have a now a chronic disease called opioid use disorder. There is a medication that will be life changing buprenorphine, and you are dependent on it. When you're taking it, you're doing life. And when you're not taking it, you're doing things that society has deemed not what we want to happen. You are lying, cheating, stealing, finding any way you can to get your money, to get your drug. And in that process, sometimes ending up in the emergency department or ending up in the criminal justice system or unfortunately dead. And so, this is a dependance and not an addiction. And so, once I worked through that and got to that part where I was

like, Oh, I get it. This is a chronic disease. When I see asthma, you need to be on a steroid inhaler. When you have high blood pressure, you need to be on lisinopril. When you're on diabetes, like my example, you need to be on insulin and no one would say you're addicted to any of those meds, but they would say you're dependent on them. I was able to get to the place that I am now.

JFB: Right. Well, thank you so much for that. Do you have any final thoughts or anything that I haven't asked you about that needs to be part of this conversation?

BF: I just want to emphasize again, if you've listened to this podcast, thank you so much for being interested in people that have opioid use disorder. They're in our community, they're actually in our waiting rooms and you're seeing them. So be ready or I encourage you to start screening and then be ready to diagnose this and help them out. Buprenorphine is a very safe and effective medication for them. And then as you start to do this, if you have discomfort or you have questions, reach out to the people around you. That's the best way to get more comfortable with this medication.

JFB: Wonderful. Well, Dr. Fagan, thank you so, so much. I really appreciate you talking through this with me.

BF: Thank you for having me.

Episode closing: 30:13

I know, I know. We just threw a whole lot of information about MAT at you. It's a lot to remember. But we are here to help. Just visit the MedBoard Matters show page at www.ncmedboard.org/podcast to find links to resources to help you follow up with anything we touched on in this podcast and more. Even if you don't think providing MAT to patients is for you, any physician or PA with an active DEA registration should definitely check out the DEA's guidance on the new training requirement. You'll find a copy of that guidance on the show page. And don't sleep on it because the mandate goes into effect pretty soon. Beginning June 27th, all DEA registrants – with the exception of veterinarians – are required to attest during registration renewal that they have completed 8 hours of training in the treatment and management of patients with opioid or other substance use disorders. Now, it's not required to complete the 8 hours by June 27th. That's just when DEA will start asking if renewing prescribers have done it. DEA registrants are meant to complete the hours by their next DEA renewal date, whenever that is. And, of course, some prescribers are exempt and there are a whole lot of other rules. Check it out. Please do your friends and colleagues a favor and share this podcast episode with them. A lot of people need to know about the developments in MAT we have talked about. Well, that brings us to the end of this episode of MedBoard Matters. As always, we invite you to send comments and questions by email to podcast@ncmedboard.org. I'm your host Jean Fisher Brinkley, signing off. I hope you will join me again.