Kentucky's Progress (& Challenges) with Prevention, Intervention & Medication-assisted Treatment

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Background: Kentucky

- The highest rate of acute hepatitis C infection in US – 3.2 cases per 100,000 population (CDC 2011 data)
- 3rd highest opioid overdose death rate (23.6 per 100,000 population) = ~2x ↑ nation's average rate (2010 data)
  - ↑ 550% in heroin-related OD from 2011 to 2012
  - Rx opioids OD – now leveling off (NOTABLY: alprazolam in 41% of our 2012 overdoses)
- 2 publically-funded opioid treatment programs: the Lexington program has a 1.5-2 year waiting list

Prevention & Intervention

- KY prescription drug disposal sites: 173 locations in 110 counties that have collected ~45k pounds since 10/2011
- Good Samaritan laws passed for naloxone overdose
  - Limited utilization
  - Lots of opportunities, particularly in rural areas with limited resources & longer times for EMS arrival due to geography

Prevention & Intervention

- ***KY Governor's KASPER Advisory Council***
  - Includes: Boards of Medical Licensure & Pharmacy, Office of Drug Control Policy, Attorney General's Office, KY Medical Association, Office of Inspector General/KASPER, physicians (pain treatment providers & addiction medicine/psychiatry providers), & more.
  - Proactively screen for worrisome opioid prescribing patterns
  - Identifies educational needs for providers
    - After passage of HB1/217 – reports of doctors firing patients based on KASPER and urine test results
    - How to interpret and respond to worrisome KASPER reports
    - How to interpret and respond to worrisome urine drug test results

Medication-assisted Treatment (MAT): Goals & Challenges

- ↓ stigmatization @ at all levels - courts, insurers “e.g., live in toxic environment?” on prior auth forms”, providers, communities
- ↑ access to MAT (majority is OBOT: 437 waivered doctors; 47% with 100 patient limit as of 4/2014; buprenorphine/naloxone prescriptions ↑↑)
  - However, access to providers that take insurance is limited
  - Publically funded treatment limited even with priority populations ex: methadone treatment ends within two months post-partum
  - Reasonable reimbursement/PA forms to encourage insurance acceptance needed
  - Need clear OBOT practice standards (in progress with KY SAM & ASAM)

Progress re: MAT & rethinking opioid prescribing for pain

- Free on-line continuing medical & pharmacy education (CME/CPE)
  - Great way to pack a room – invites from ODCP & state board of medical licensure – can then videotape for on-line viewing
  - Sample of topics covered: Opioid prescribing for pain, MAT and compassionate care of the pregnant opioid addicted woman, therapeutic use of KASPER and urine drug testing in general medical practice, practices to reduce buprenorphine misuse/diversion in OBOT (average buprenorphine/naloxone doses in KY have ↓ from over 24 to 18 mg)
  - Thousands of downloads, amazing self-disclosures ("aha" moments) & also possible to knowledge & practice behavior outcomes[1]
  - Available @ http://www.cecentral.com/search/specialty/85

1. Lofwall et al. Efficacy of continuing medical education to reduce risk of buprenorphine diversion. J Subst Abuse Treat. 2011: 41:321-9.

Conclusions

- KY Governor's KASPER Advisory Council: Helps all members involved in the current opioid epidemic (rx opioids and heroin) better understand the "big (& complex) picture" of opioids for pain and opioid addiction. It also, in my opinion, serves to prevent well-intentioned but potentially harmful policies from coming to fruition.
- Good start and a long way to go, but with many opportunities and luckily with great partners.

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