

Physician Assistants' Interest in Prescribing Buprenorphine for Opioid Addiction

Valerie Spiser* & Stephanie Dumolt
Faculty: Patricia A. Bunton

Department of Physician Assistant

Abstract. Under current legislation, only certified physicians can prescribe buprenorphine for opioid addiction. Due to geographic maldistribution and the limited number of certified physicians, patients in rural areas may have to travel large distances to receive treatment. Allowing PAs to prescribe buprenorphine may provide treatment to a larger population. This study investigated Kansas PAs' interest in prescribing buprenorphine for opioid addiction treatment and their opinions regarding legislative changes allowing PAs to prescribe buprenorphine. Surveys were sent to all practicing PAs in Kansas. Results were collected and analyzed in a non-identifiable format. The majority of respondents reported supporting legislative changes allowing PAs to prescribe buprenorphine for opioid addiction. Of those practicing in primary care, 29% reported interest in becoming certified.

1. Introduction

Opioid abuse is a major problem in the United States today. The 2006 National Survey on Drug Use and Health reported nearly 10% of the population aged 12 and over required treatment for drug or alcohol abuse[1]. Buprenorphine (Subutex®) and buprenorphine/naloxone (Suboxone®) are schedule III controlled substances approved by the Food and Drug Administration (FDA) for treatment of opioid addiction [1]. Therefore, they have less abuse potential than methadone (Schedule II medication), which is also used for addiction treatment. The Drug Addiction Treatment Act of 2000 allowed physicians, but not Physician Assistants (PAs) and Nurse Practitioners (NPs), to prescribe opioids for treatment of drug addiction[2]. Prior to this act, patients seeking treatment for opioid addiction were limited to federally-regulated inpatient treatment programs. Because buprenorphine treatment may be managed in an outpatient setting, daily visits to clinics and extended stays at treatment facilities may be eliminated. This allows patients more flexibility and more control over their treatment[3].

According to the Lexi-Comp Drug Information Handbook, "Buprenorphine exerts its analgesic effect via high affinity binding to μ opiate receptors in the CNS [central nervous system][4]." Buprenorphine functions as a partial opioid agonist, mimicking natural opioids without exerting their full euphoric effect. Since buprenorphine has a higher affinity for μ receptor sites, it displaces full agonist opioids and blocks them from the binding sites[3]. The naloxone component in Suboxone® is used as a deterrent to keep addicts from crushing and injecting the tablets for an additional euphoric effect. Injection of Suboxone® will cause unpleasant withdrawal symptoms[5]. In an outpatient setting, Suboxone® is usually administered sublingually, minimizing withdrawal side effects of naloxone.

Under current legislation, PAs cannot prescribe buprenorphine[2]. To become eligible to prescribe buprenorphine, board-certified physicians must take an eight hour training course. These physicians will obtain a special DEA number, allowing them to prescribe buprenorphine to a maximum of 30 patients[6]. After one year, physicians may apply for a waiver, permitting them to treat up to 100 patients at one time[1].

In Kansas, there are currently 46 physicians certified to prescribe buprenorphine and eight treatment facilities[1]. Because of the limited number of certified providers and their locations in primarily densely-populated areas, patients in rural areas of Kansas may have to travel long distances to receive treatment. The PA profession was initially created due to the shortage of physicians and the maldistribution of their geographic location and specialties[7]. Allowing PAs to prescribe buprenorphine would make treatment available to a larger population. Kansas legislators will be voting this year on amending the DATA 2000 which would allow PAs to prescribe buprenorphine.

2. Study, Results, Discussion, and Significance

This study investigates Kansas PAs' interest in prescribing buprenorphine for opioid addiction treatment and their attitudes and beliefs regarding legislative changes to permit PAs to prescribe buprenorphine. E-mail addresses of all PAs practicing in Kansas were obtained from the Board of Healing Arts. Surveys were sent by surveymonkey.com to all practicing PAs in Kansas. A cover letter explaining buprenorphine's therapeutic uses and legal prescribing limitations was sent with the survey. The survey included questions concerning demographic information of survey participants as well as questions regarding perception of need for opioid addiction treatment

within their community and individual attitudes concerning obtaining certification to prescribe buprenorphine should legislation be changed permitting PAs to take on this responsibility.

Survey results were collected using surveymonkey.com in a non-identifiable format from December 2010 to February 2011. Responses to questions regarding PAs' opinion were limited to "yes," "no," and "unsure". Participants were encouraged to add additional comments to explain their choices. The survey proposal was submitted to the Wichita State University Review Board and approved prior to distribution.

Of the 615 e-mail recipients, 150 responded, a 24.4% response rate. Fifty-three percent of respondents believed that legislation should be changed to allow PAs to prescribe buprenorphine and 32% were unsure. Of the 66 respondents practicing in primary care, 29% were interested in becoming certified if legislation was changed with 15% being unsure and 50% believed there was a need for more certified buprenorphine prescribers in their community, while 39% were unsure. Of those in primary care, 65% reported having to turn patients away or recommend another location for opioid addiction treatment. The average distance from their practice to the nearest certified provider site was 28.87 miles. Of those who practice in rural or frontier communities, the average distance was 42.6 miles, with more than one response of 150 miles.

Kansas PAs were expected to exhibit a significant interest in prescribing buprenorphine specifically for treatment of patients with opioid addiction. Should legislation be changed, they were also expected to be willing to take the required training. Survey results showed that PAs support efforts to make legislative changes possible. More than a fourth of the respondents in primary care would be willing to become certified, should legislation be changed. If PAs are permitted to take on this responsibility, it will provide more access to treatment resulting in better patient care.

Limitations of this study include a small survey population and a low survey response rate. A survey of PAs nationwide would be of greater benefit. We were unable to filter our contact e-mail addresses by specialty. Therefore, we surveyed PAs practicing in all specialties, and filtered the results by their self-identified specialty. This survey could be improved if only PAs practicing in primary care (excluding pediatrics) could be surveyed. This survey also does not take into account which certified providers have met the maximum amount of buprenorphine patients. Therefore, the closest distance to a certified buprenorphine provider that PAs reported may actually be further if the closest provider is not accepting new patients. The survey did not take into account any possible negative aspects of potential changed legislation.

3. Conclusions

This study showed the majority of Kansas PAs practicing in primary care believe that legislative changes should be made to allow PAs to prescribe buprenorphine. More than a fourth of the respondents in primary care would be willing to become certified, should legislation be changed.

4. Acknowledgements

We would like to acknowledge the Kansas State Board of Healing Arts for providing the PA contact information. We would like to thank LaDonna Hale, Pharm.D. for her insight on both pharmacology and research. We would also like to thank Dr. Tim Scanlan, for providing us with his addiction treatment expertise.

References

- [1] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Buprenorphine. Available at: www.buprenorphine.samhsa.gov. Accessed November 20, 2009.
- [2] Drug Addiction Treatment Act of 2000, Title XXXV of the Children's Health Act of 2000. Pub L. No. 106-310, 116 Stat 1222. Oct 17, 2000.
- [3] The National Alliance of Advocates for Buprenorphine Treatment. How Buprenorphine Works & FAQs. Available at: www.naabt.org. Accessed November 29, 2009.
- [4] Lacy CF, Armstrong LL, Goldman MP, et al. *Drug Information Handbook: A Comprehensive Resource For All Clinicians and Health Care Professionals*. 16th ed. Hudson, Ohio: Lexi-Comp. 2008; 221-223.
- [5] Suboxone®. About Suboxone®. Available at: www.suboxone.com. Accessed November 29, 2009.
- [6] Dipro JT, Talbert RL, Yee GC, et al. *Pharmacotherapy: A Pathophysiologic Approach*. 7th ed. New York, NY: McGraw-Hill Medical; 2008: 1079.
- [7] Ballweg R. History of the profession and current trends. In: Ballweg R, Sullivan EM, Brown D, et al. *Physician Assistant: A Guide to Clinical Practice*. 4th ed. Philadelphia, PA: Saunders Elsevier; 2008: 1-30.