Office-based Treatment of Opioid Dependence with Buprenorphine: Follow-up Q & A Webinar with Case Discussions

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Dr. Fiellin’s Disclosures

• Dr. Fiellin has received honoraria from Pinney Associates for serving on external advisory boards monitoring the diversion and abuse of buprenorphine.

The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.
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Target Audience

• The overarching goal of PCSS-O is to offer evidence-based trainings on the safe and effective prescribing of opioid medications in the treatment of pain and/or opioid addiction.

• Our focus is to reach providers and/or providers-in-training from diverse healthcare professions including physicians, nurses, dentists, physician assistants, pharmacists, and program administrators.
Educational Objectives

- Describe the legislation relevant to office-based treatment with buprenorphine.
- Describe how to establish the diagnosis of opioid dependence.
- Describe the effectiveness of office-based treatment of opioid dependence.
Outline

• Drug Addiction Treatment Act of 2000 and Buprenorphine
• Establishing the Diagnosis Opioid Dependence
• Treatments for Opioid Dependence
• Components of Office-based Treatment of Opioid Dependence with Buprenorphine
• Effectiveness of Office-based Treatment of Opioid Dependence with Buprenorphine
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Federal Efforts to Increase Access
Fiellin and O’Connor, NEJM 2002

Congress (2000)
- Drug Addiction Treatment Act
  - Allows qualifying physicians to use approved schedule III-V medications
  - “Qualifying physician” (defined later)

FDA and DEA (2002)
- Approve buprenorphine and buprenorphine/naloxone for treatment of opioid dependence, schedule III
Practitioner requirements:

- “Qualifying physician”
- Has capacity to refer patients for appropriate counseling and ancillary services
- No more than 30 patients (in first year). Can notify Center for Substance Abuse Treatment after one year and increase to 100 patients
Buprenorphine

- Partial agonist at mu opioid receptor
- Lower abuse and diversion potential relative to full mu opioid agonists, especially when combined with naloxone
- Sublingual tablets (buprenorphine alone and buprenorphine/naloxone) or film (buprenorphine/naloxone)
- Prescribed by physicians and available at pharmacy
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Opioid Dependence
(DSM-IV, 3 or more within one year)

Physical Dependence
• Tolerance
• Withdrawal

Loss of control (addiction)
• Larger amounts/longer period than intended
• Inability to/persistent desire to cut down or control
• Increased amount of time spent in activities necessary to obtain opioids
• Social, occupational and recreational activities given up or reduced
• Opioid use is continued despite adverse consequences
Pathophysiology of Opioid Dependence

- Opioid dependence is a chronic, relapsing medical condition with biologic and behavioral components.
- Neurobiological changes accompany the transition from use to dependence.
- Neurobiological changes explain relapse even after “detoxification”.
- Neurobiological changes form the rationale for the pharmacologic treatments.
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Treatment Options for Opioid Dependence

High rates of relapse with:

• Pharmacologic withdrawal - “detoxification”
  o Followed by medication-free treatments
• Opioid antagonist treatment
  o Naltrexone

Most effective treatments are opioid agonist treatments

• Methadone
• Buprenorphine
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Components of Office-based Treatment of Opioid Dependence with Buprenorphine

- Physician with appropriate DEA registration
- Onsite or off-site counseling services
- Urine toxicology monitoring
- Pharmacy
- Method to screen for appropriate patients
- See [http://pcssmat.org/resources/essential-materials/#1382013035-2-36](http://pcssmat.org/resources/essential-materials/#1382013035-2-36) for examples of materials below:
  - Treatment agreements
  - Procedures for release of information
  - Patient log to avoid exceeding patient limit
Selecting Patients Who Are Appropriate for the Office

• Determine appropriateness of patient for office based buprenorphine treatment by considering the needs of the patient and the available resources

• For patients whose needs exceed that of the office, referral to alternative offices or specialty treatment programs is appropriate and prudent
  o http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx
  o http://buprenorphine.samhsa.gov/bwns_locator/
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• Treatment practices
• Mental health and substance use among those seeking treatment
• Outcomes
  o Retention and Drug use
  o HIV risk behaviors
  o Patient satisfaction
  o Provider satisfaction and challenges
Table 2. Treatment Outcomes at 12 Months of 382 Opioid-Dependent Patients Entering Office-Based Opioid Treatment in Primary Care

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Patients, No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful treatment</td>
<td>196 (51.3)</td>
</tr>
<tr>
<td>Treatment retention</td>
<td>187 (49.0)</td>
</tr>
<tr>
<td>Successful taper after 6 months of adherence(^a)</td>
<td>9 (2.4)</td>
</tr>
<tr>
<td>Unsuccessful treatment</td>
<td>162 (42.4)</td>
</tr>
<tr>
<td>Lost to follow-up</td>
<td>113 (29.6)</td>
</tr>
<tr>
<td>Nonadherence despite enhanced treatment(^a)</td>
<td>46 (12.0)</td>
</tr>
<tr>
<td>Administrative discharge due to disruptive behavior</td>
<td>2 (0.5)</td>
</tr>
<tr>
<td>Adverse effects of buprenorphine hydrochloride</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td>Transfer to methadone hydrochloride treatment program</td>
<td>24 (6.3)</td>
</tr>
</tbody>
</table>

\(^a\) Denotes outcomes with fewer than 20 patients.
Physician’s Perception of Challenges Decrease with Experience

1 = doesn’t affect at all
5 = strongly affects
Physician Clinical Support for Office-based Medication Assisted Treatment

• PCSS-MAT [http://pcssmat.org](http://pcssmat.org)
  - Offers waiver trainings at no charge
• Network:
  - National Experts
  - Mentoring physicians
• Services:
  - Telephone, email support, site visits
• Web-based content:
  - Treatment guidances
  - Didactics
  - Clinical Resources

Egan, JGIM, 2010
Summary

- Opioid dependence due to prescription opioids and heroin is prevalent and increasing
- The neurobiological changes that occur in opioid dependence respond to medication and counseling
- Office-based treatment with buprenorphine is a viable option under DATA 2000
- Matching patients to office-resources is important
- With office-based treatment:
  - Drug use decreases for many
  - Retention is modest
  - Patient satisfaction is high
  - Provider satisfaction is high and challenges decrease with time
- Support systems such as PCSS-MAT can help expand office-based treatment with buprenorphine
Follow-up

- Patient compliance
- Insurance or reimbursement costs
- Consensus/compliance from other departments or colleagues
- Administrative support not available
- Insufficient time for implementation
1. What do you recommend for patients who referred to me from other docs and are on large amounts of buprenorphine say 4-8 mgs films a day?

2. How do we decide the correct maintenance dose for a patient? Medicaid here mandates maintenance dose of $\leq 16$ mg per day after 6 months.

3. Transfer from office based buprenorphine to an OTP

4. More information about non-supervised induction protocol

5. Please explain the method of counting the number of patients e.g. 100 patients monthly or biweekly?
Mrs. Ash is a 59 year old female with osteoporosis, depression, nicotine dependence and of low back pain secondary to vertebral compression fractures. She is referred to you by her primary care physician, at the request of her daughter, who says her mother is addicted to narcotics. Mrs. A reports that she wakes with LBP that gradually improves during the day if she takes her sustained release MSO4. Once or twice a day she takes a hydrocodone/acetaminophen if she is going to go out shopping or walking with her friend, daughter and granddaughter.

Mrs. Ash comes to her primary care visits every 3 months, participates with physical and aquatherapy twice a week, and has been adherent to her CaCO3, pamidronate, fluoxetine, and MSO4 prescriptions. Two years ago she received 20 mg of MSO4 bid, now she receives 40 mg of MSO4 bid and prn hydrocodone/acetaminophen.

Is this patient opioid dependent? Should she receive methadone or buprenorphine?
39-year old graphic artist who has been in treatment and doing well on 16 mg per day of buprenorphine for the last 12 months. He married 6 months ago, and he and his wife are expecting a baby in 5 months. He tells you that he wants to be off maintenance treatment when his child is born. His wife supports his decision, but does not think it is necessary. She says she does not want to risk his using drugs again. They both say that getting treatment (buprenorphine and counseling) without disrupting his job made all the difference. He feels like he now has his life back.

He made a successful entry into treatment and had been stable for 6 months when urine drug screens were positive for heroin and cocaine. He said that he used heroin when school buddies came into town for a conference, and then he continued to use for two weeks. His wife didn’t know about his relapse. You changed his appointments for urine testing to weekly and increased his counseling appointments to twice weekly for 3 months. After that period (3 months), there were no positive urine drug screens. His wife, his counselor and you have seen treatment stability since then.
References


References


References


PCSS-O Colleague Support Program and Listserv

- PCSS-O Colleague Support Program is designed to offer general information to health professionals seeking guidance in their clinical practice in prescribing opioid medications.

- PCSS-O Mentors comprise a national network of trained providers with expertise in addiction medicine/psychiatry and pain management.

- Our mentoring approach allows every mentor/mentee relationship to be unique and catered to the specific needs of both parties.

- The mentoring program is available at no cost to providers.

For more information on requesting or becoming a mentor visit: www.pcss-o.org/colleague-support

- Listserv: A resource that provides an “Expert of the Month” who will answer questions about educational content that has been presented through PCSS-O project. To join email: pcss-o@aaap.org.
PCSS-O is a collaborative effort led by American Academy of Addiction Psychiatry (AAAP) in partnership with: American Dental Association (ADA), American Medical Association (AMA), American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA), American Society for Pain Management Nursing (ASPMN), and International Nurses Society on Addictions (IntNSA).

For more information visit: www.pcss-o.org
For questions email: pcss-o@aaap.org

Twitter: @PCSSProjects

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