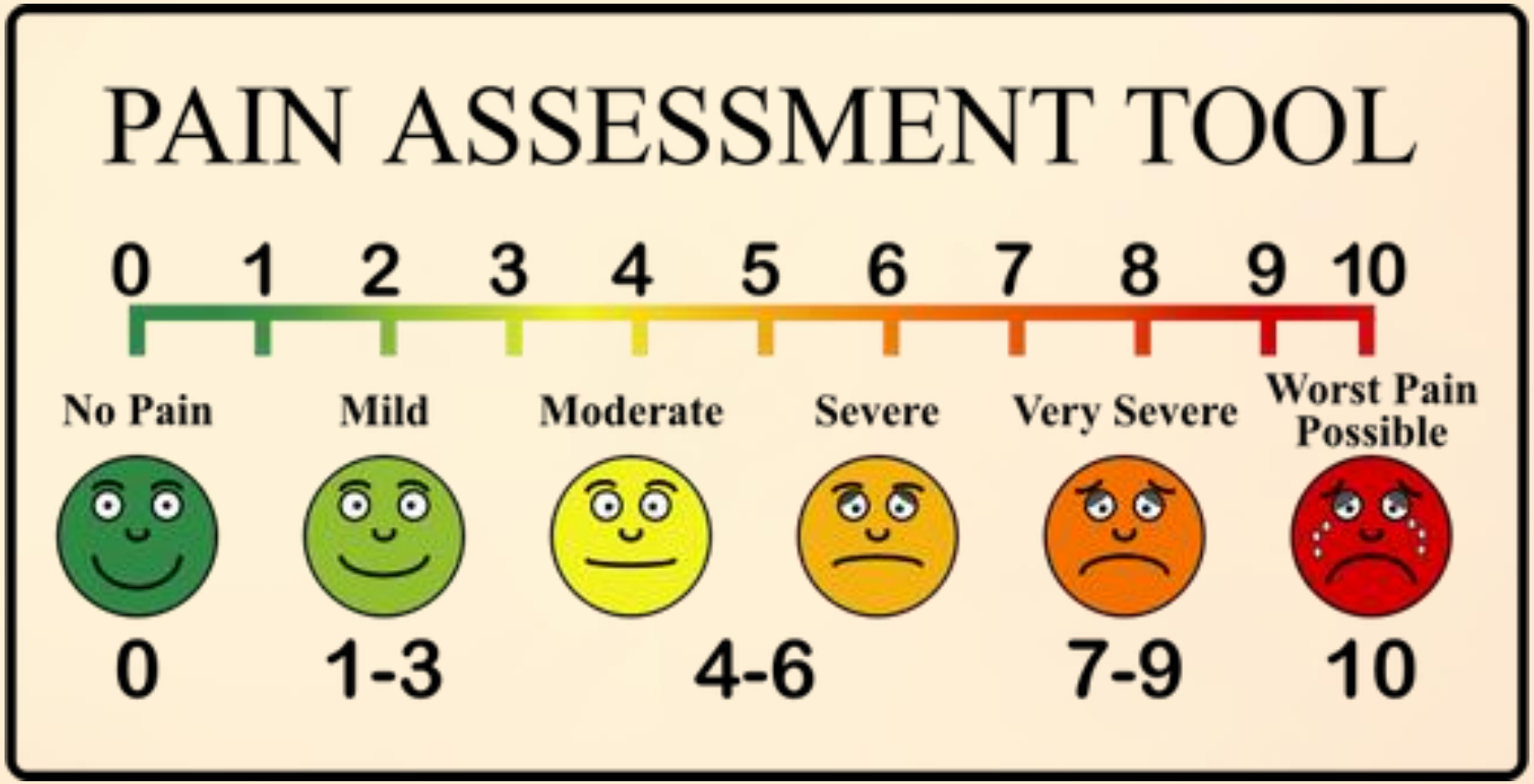
The Joy of Buprenorphine

Joyce Troxler, MD and Jonathan Leggett, PhD
60th Annual Family Medicine Conference, NMAFP
Friday July 28, 2017

video

- https://youtu.be/H8fUCfIKMo4

PAIN ASSESSMENT TOOL



How Did We Get Here?

- Pain as the 5th Vital Sign
  - 11/11/1996 – American Pain Society introduced the phrase “Pain as the 5th Vital Sign”
  - Veteran's Health Administration included the 5th Vital Sign
  - Joint Commission released “Standards Related to the Assessment and Treatment of Pain”
  - Motivation to care for aspects of care not fully addressed in the past as robustly as could have been, but…
  - RX Opioids are now the leading cause of drug overdose deaths

How Did We Get Here?

- Independent Research reinforcing the prevailing sentiment of the need to treat chronic, non-cancer pain with opioids
- Marketing by pharmaceutical companies

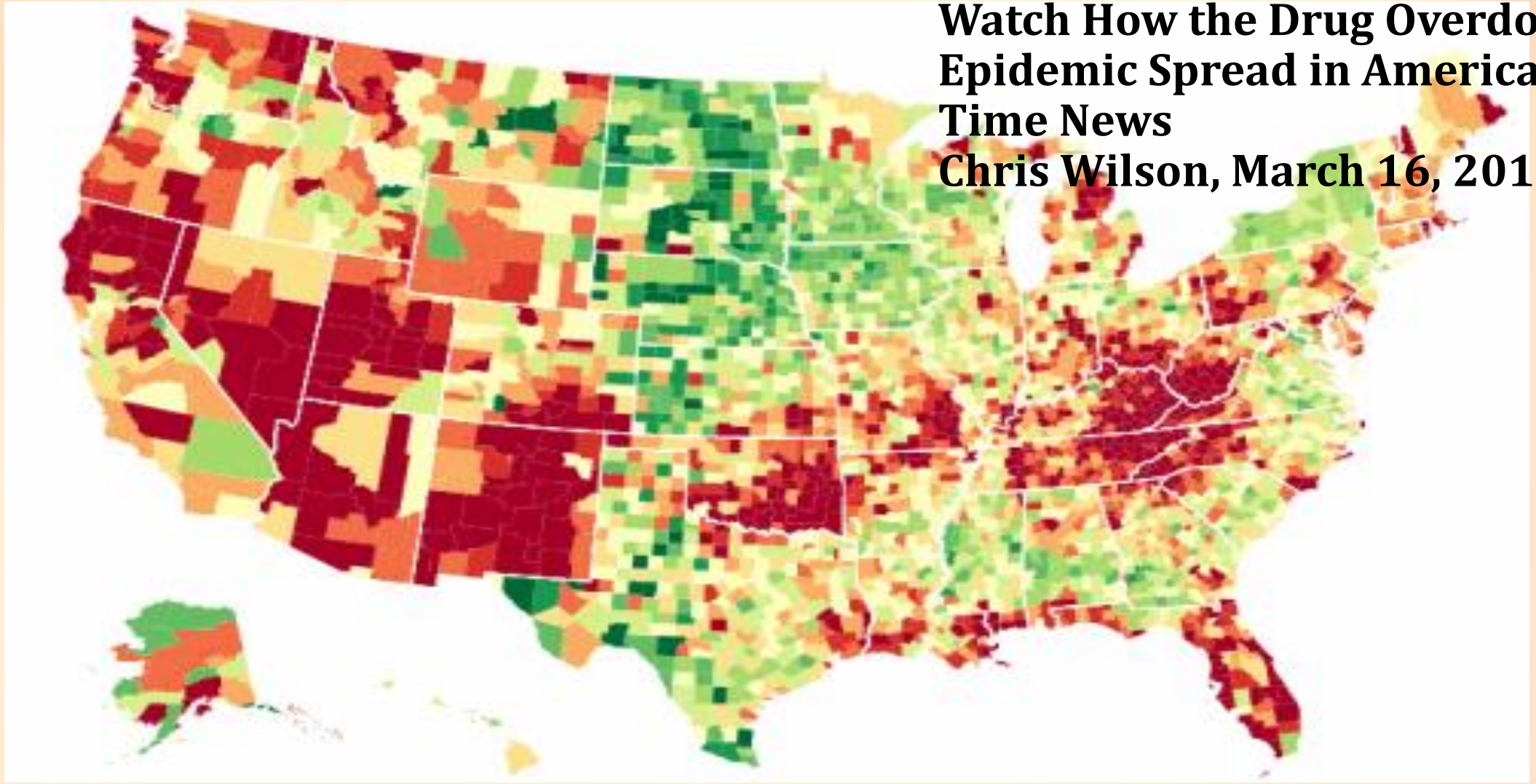
How Did We Get Here?

- ACEs – Adverse Childhood Events
  - The higher the score the more likely the individual will have poor health and social outcomes
  - Those with an ACE score of 5 or more were 7-10x more likely to use illegal drugs, report addiction and inject illegal drugs
  - ACE score of 4 increases likelihood of becoming an alcoholic by 700%, and risk of attempted suicide 1200%

Objectives

- Develop an understanding of why providing comprehensive Medication Assisted Treatment services is beneficial to patients, community and providers
- Develop an understanding of Medication Assisted Treatment phases of development/treatment in the Outpatient Treatment Program
- Develop an understanding of running your own Outpatient Treatment Program

Watch How the Drug Overdose Epidemic Spread in America
Time News
Chris Wilson, March 16, 2016



RED is >20 per 100,000 residents

GREEN is 0-2

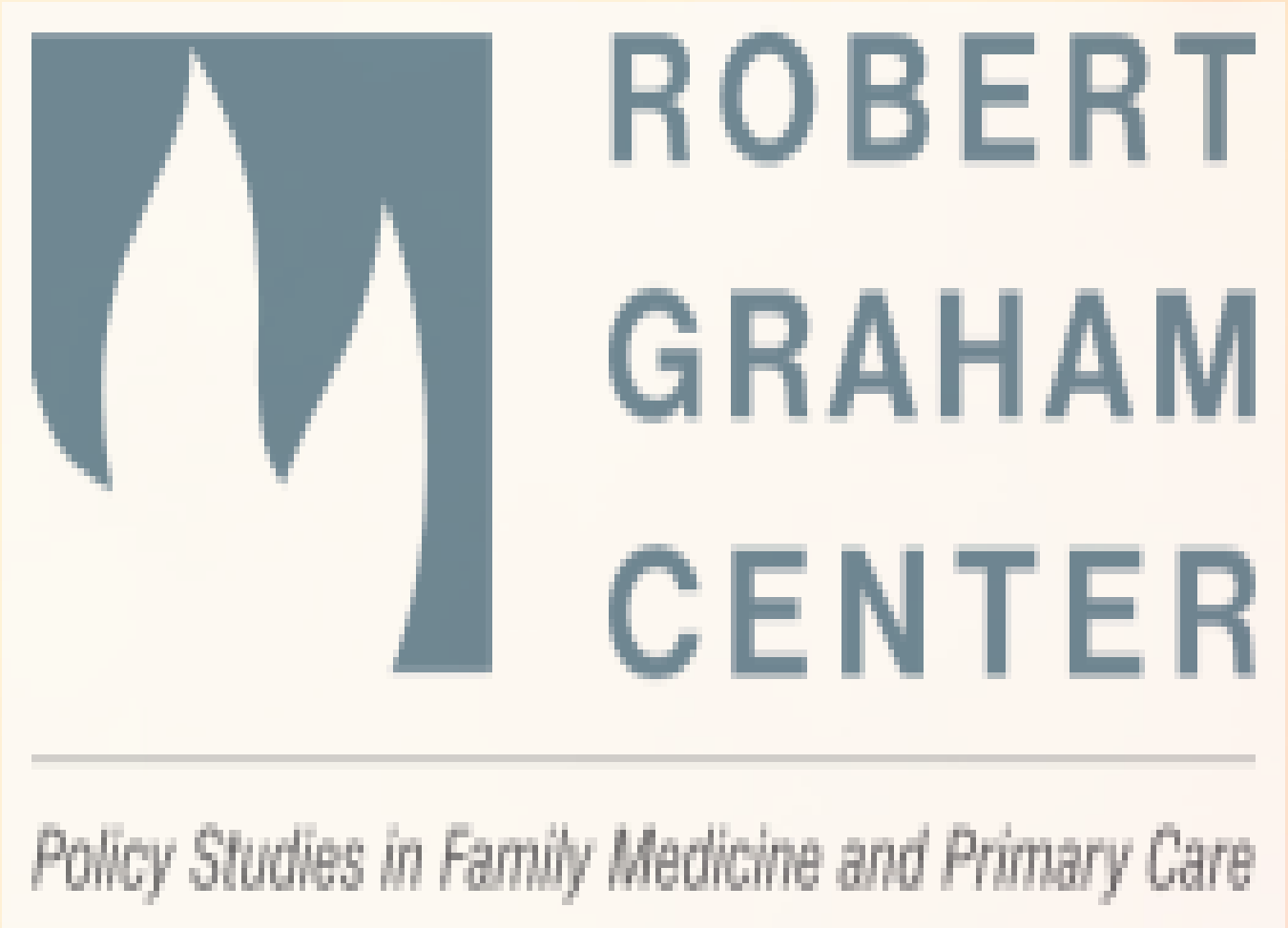
"The Centers for Disease Control estimates that there are 825 non-medical users of opioid drugs or heroin for every overdose death..."

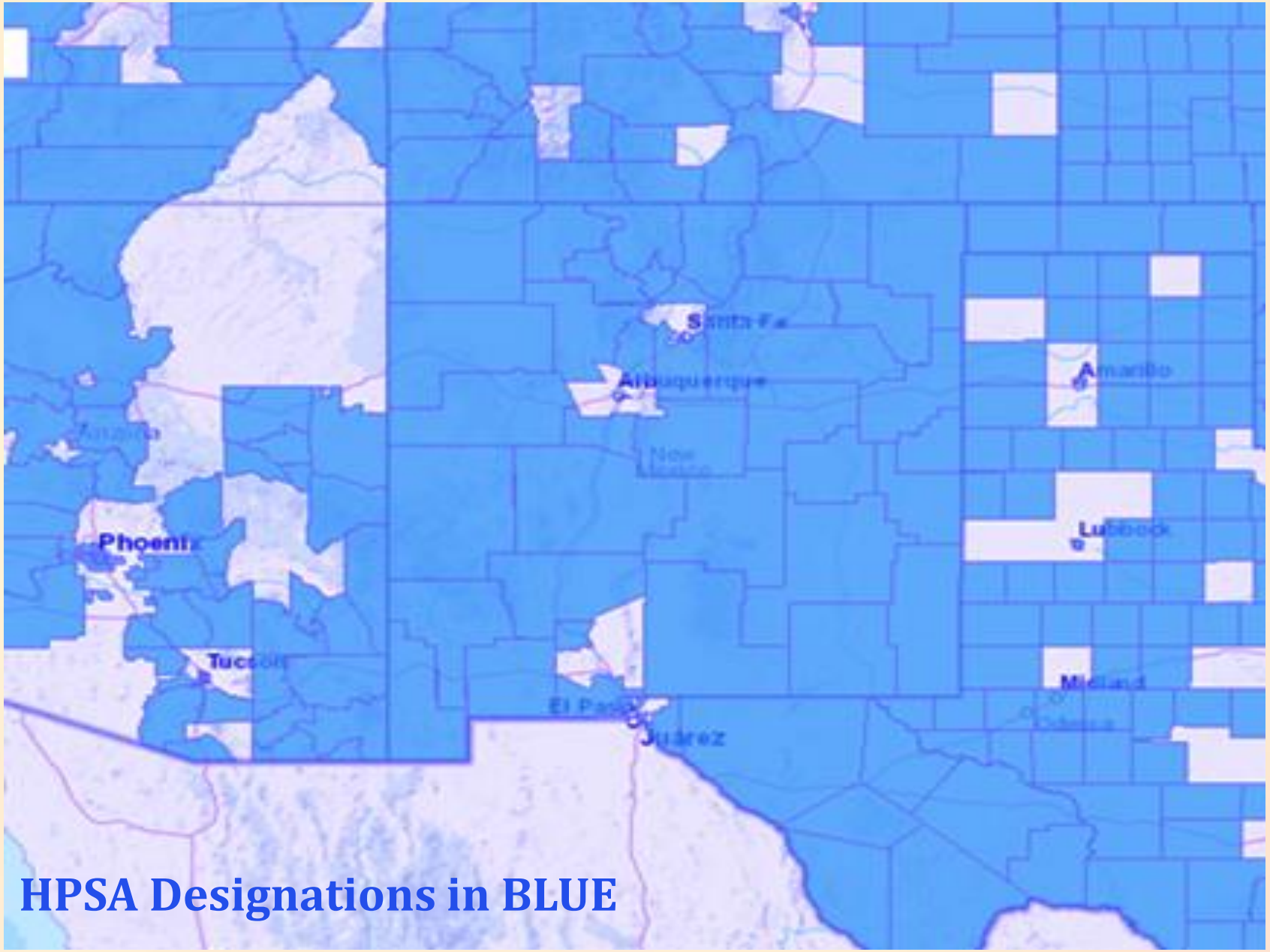
Forum to address New Mexico's opiate addiction crisis

By ABQJournal News Staff

Published: Friday, May 27th, 2016 at 11:51pm

- “The nation’s growing opioid use disorder epidemic disproportionately impacts rural areas, where physicians who can prescribe buprenorphine are scarcest. Among physicians approved to prescribe buprenorphine, family physicians (FPs) are the most likely to work in rural areas.”





HPSA Designations in BLUE

Distribution of DATA Waived Physicians in US

- 1/3 were psychiatrists, and only 5.5% were in rural areas
- 1 out of 5 represented FM docs, and 15% lived in rural areas – very close to the 17% of the US population that lives in rural US

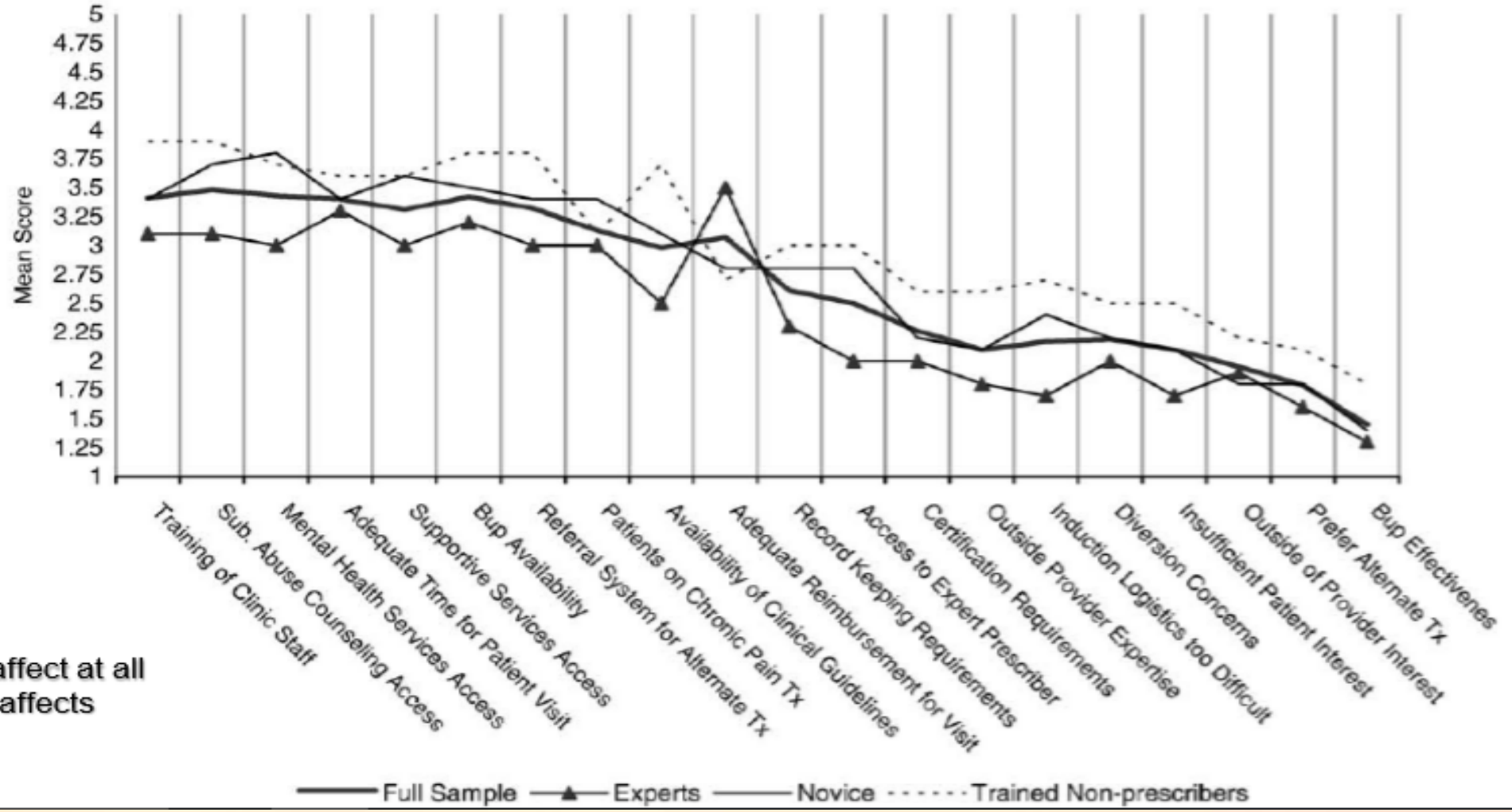
How many have XDEA but aren't using it, and why?

Perceived Challenges

Never felt comfortable starting

Got burnt out

Physician's Perception of Challenges Decrease with Experience



1 = doesn't affect at all
5 = strongly affects

Good for Providers

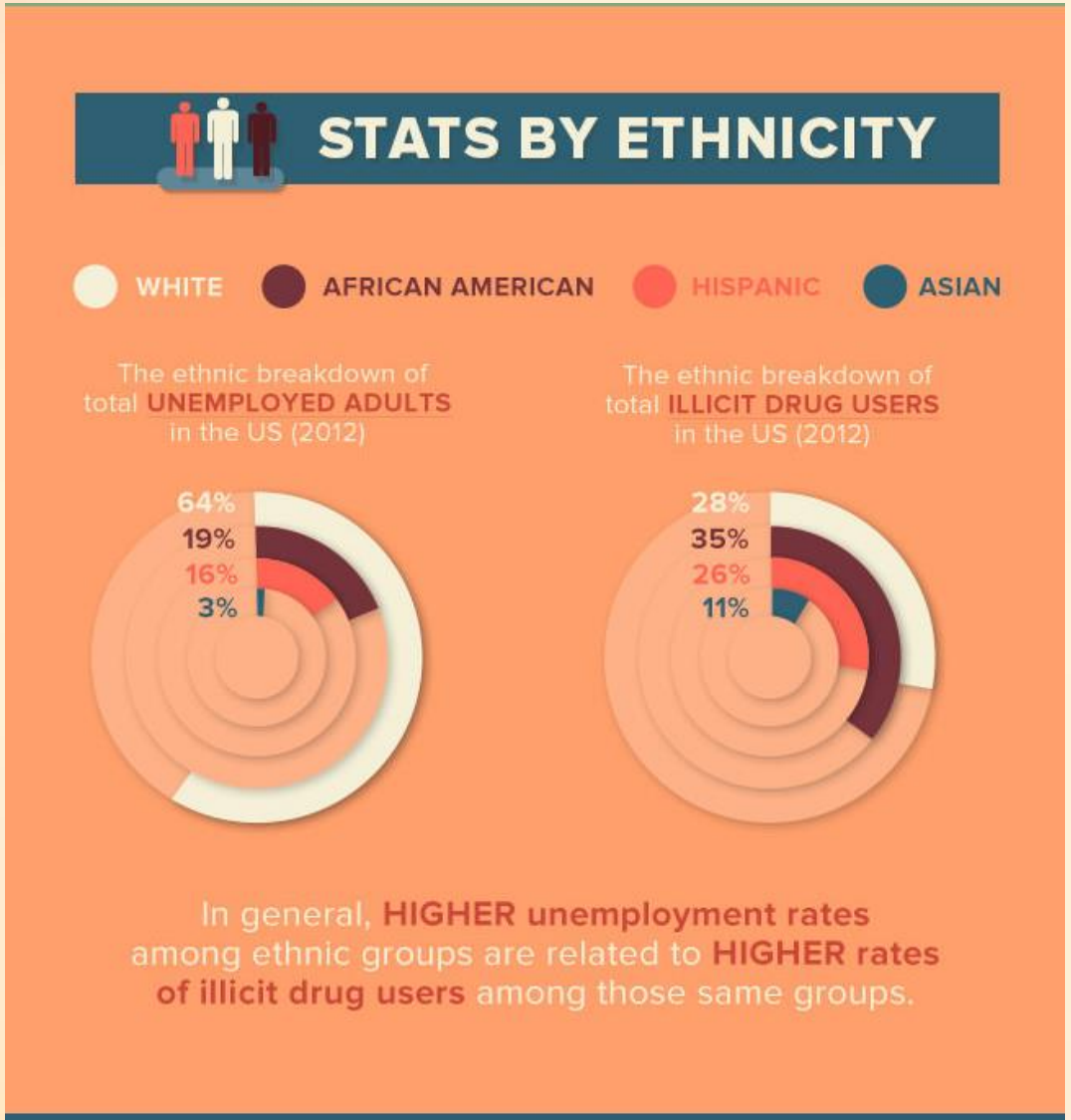
- Short term and long term sense of satisfaction.
- Patients get better
- Less feeling of being manipulated or helpless in the context of addiction
- Ability to focus on a large issue that has negative impact on patient's global existence and enable improved outcomes for that individual and your community
- Patients say "Thank you"

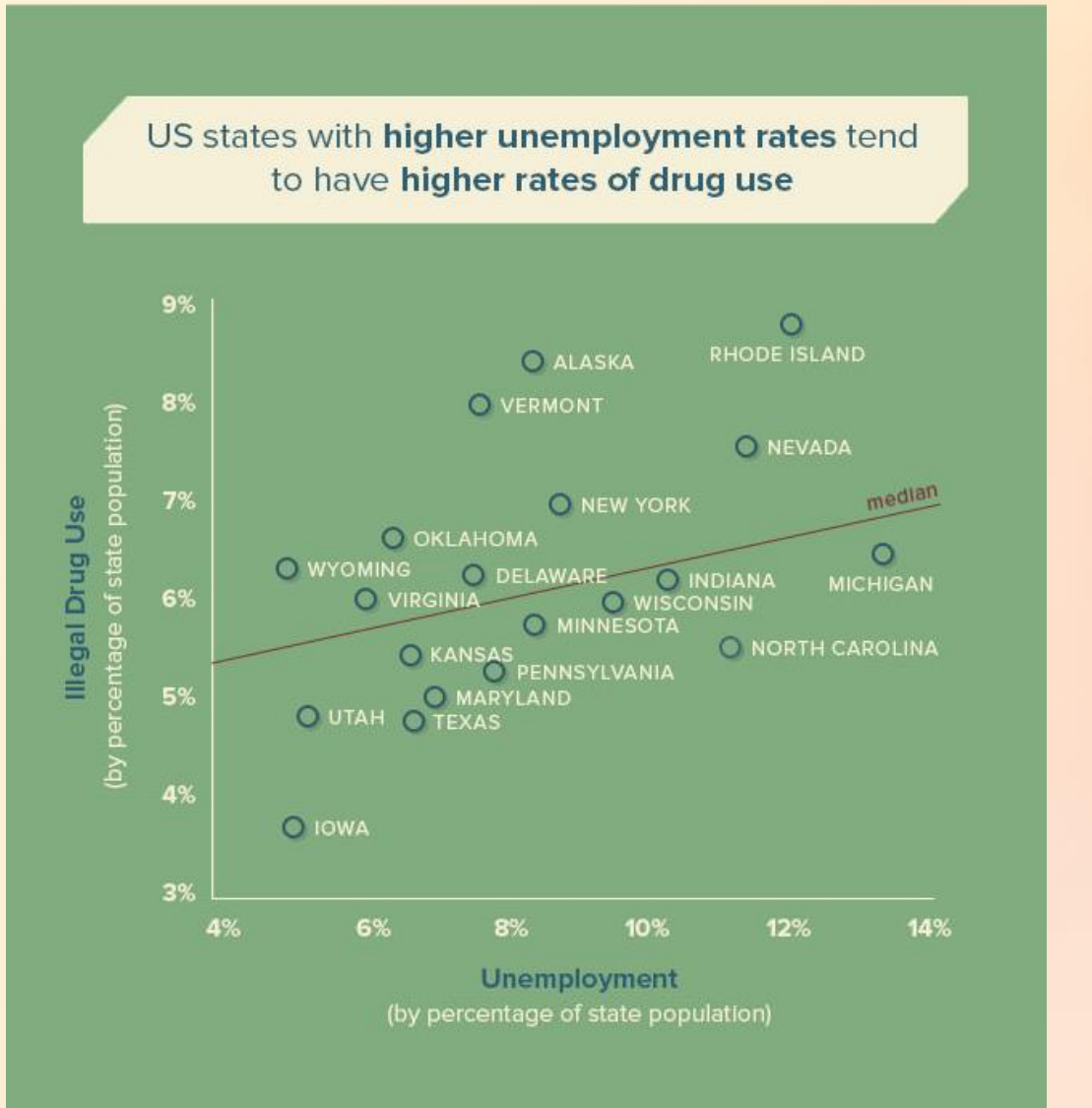
Good for Patients

- For those with opioid addiction, buprenorphine offers:
  - An opportunity for abstinence from illicit opiates and other substances.
  - Harm reduction in relationships, employment, and legal consequences.
  - Decreased health needs (as noted in decreased utilization of ERs and inpatient needs)
  - Better sense of quality of life
  - More treatment flexibility and safety than some other MATs.

Good for Community (Employment)

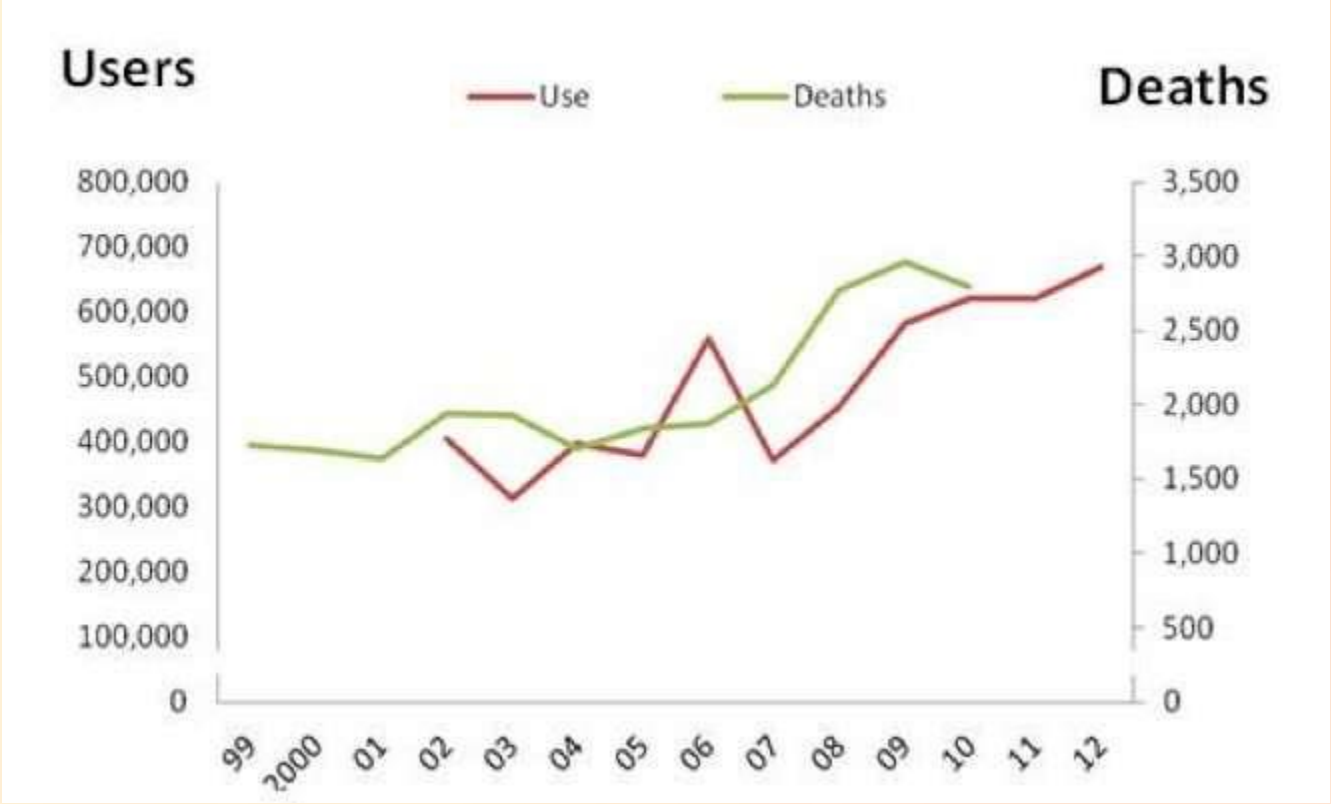
Unemployment rates are strongly correlated to drug use





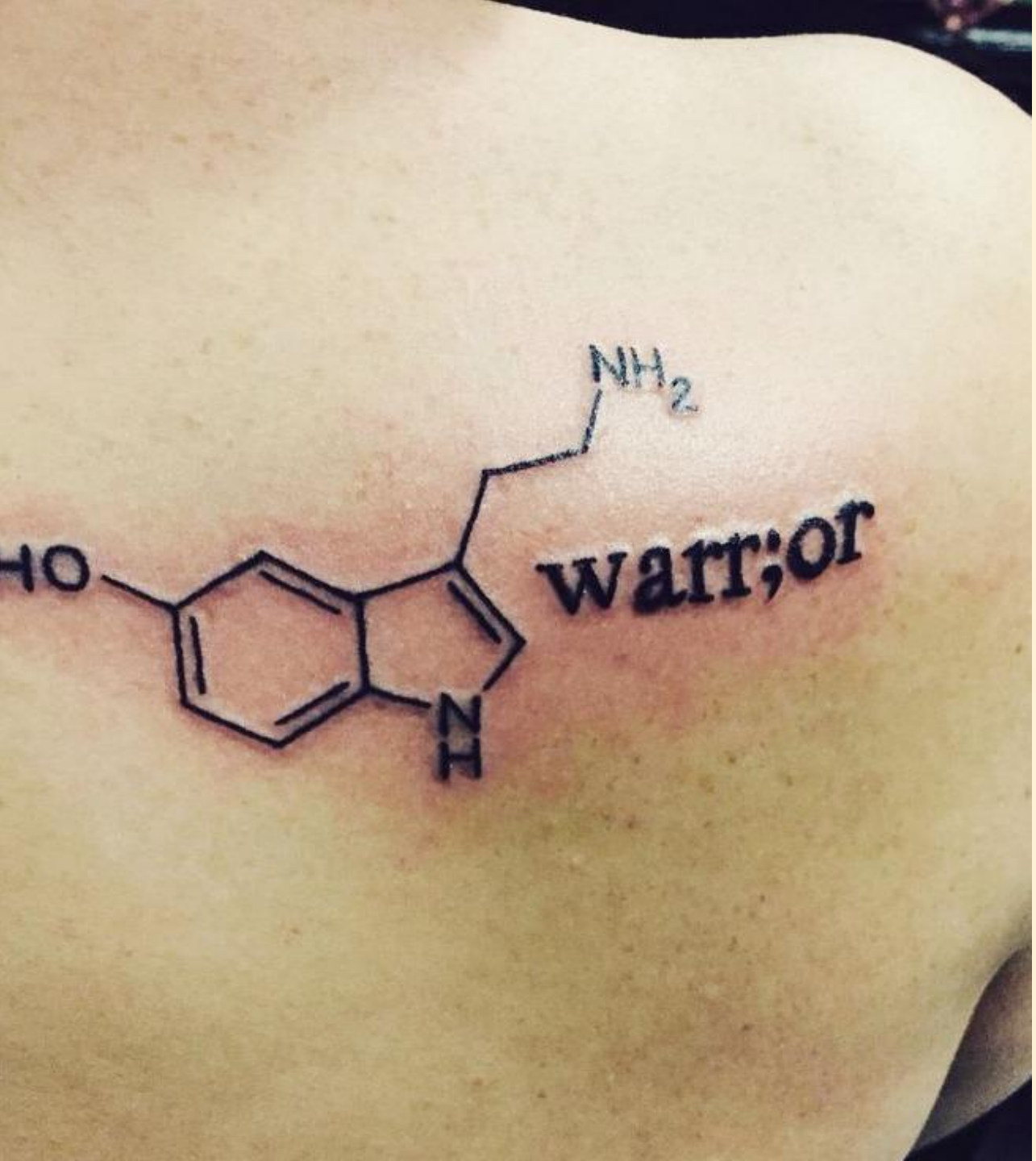
Good for Community (Reduced Crime/Death)

- Sober patients can participate more fully in routine life activities, such as holding jobs, caring for their children
  - 80% of offenders abuse drugs or alcohol.
  - Nearly 50% of jail and prison inmates are clinically addicted.
  - Approximately 60% of individuals arrested for most types of crimes test positive for illegal drugs at arrest.



A former drug dealer

who wanted to get away from the lifestyle came in for treatment...I like to think of him as my first community health worker.



Treatment Phases

Phases of Treatment

- Acute
- Rehabilitative
- Supportive
- Medical Maintenance
- Taper and Readjustment
- Continuing Care


THE SEVEN AGES OF MAN
SLEEPY
HAPPY
DOPEY
BASHFUL
DOC
SNEEZY
GRUMPY

ACUTE (**Trust vs Mistrust**)

- **Goals of the acute phase**
- A major goal during the acute phase is to eliminate use of illicit opioids for at least 24 hours, as well as inappropriate use of other psychoactive substances. This process involves
- Initially prescribing a medication dosage that minimizes sedation and other undesirable side effects
- Assessing the safety and adequacy of each dose after administration
- Rapidly but safely increasing dosage to suppress withdrawal symptoms and cravings and discourage patients from self-medicating with illicit drugs or alcohol or by abusing prescription medications
- Providing or referring patients for services to lessen the intensity of co-occurring disorders and medical, social, legal, family, and other problems associated with opioid addiction
- Helping patients identify high-risk situations for drug and alcohol use and develop alternative strategies for coping with cravings or compulsions to abuse substances.

REHABILATATIVE (**Autonomy vs Shame**)

- The primary goal of the rehabilitative phase of treatment is to empower patients to cope with their major life problems—drug or alcohol abuse, medical problems, co-occurring disorders, vocational and educational needs, family problems, and legal issues—so that they can pursue longer term goals such as education, employment, and family reconciliation.

SUPPORTIVE CARE PHASE (**Initiative vs. Guilt**)

- After meeting the criteria for transition from the rehabilitative phase, patients should progress to the supportive-care phase, in which they continue opioid pharmacotherapy, participate in counseling, receive medical care, and resume primary responsibility for their lives. During this phase, patients should begin to receive take-home medication for longer periods and be permitted to make fewer OTP visits.

MEDICAL MAINTENANCE (**Industry vs Inferiority**)

- 2 years of continuous treatment
- Abstinence from illicit drugs and from abuse of prescription drugs for the period indicated by Federal and State regulations (at least 2 years for a full 30-day maintenance dosage)
- No alcohol use problem
- Stable living conditions in an environment free of substance use
- Stable and legal source of income
- Involvement in productive activities (e.g., employment, school, volunteer work)
- No criminal or legal involvement for at least 3 years and no current parole or probation status
- Adequate social support system and absence of significant unstabilized co-occurring disorders.

TAPERING AND READJUSTMENT (**Identity vs. Role Confusion**)

- Any decision to taper from opioid treatment medication be made without coercion and include careful consideration of a patient's wishes and preferences, level of motivation, length of addiction, results of previous attempts at tapering, family involvement and stability, and disengagement from activities with others who use substances.
- As medication is being tapered, intensified services should be provided, including counseling and monitoring of patients' behavioral and emotional conditions.
- Many patients who complete tapering from opioid medication continue to need support and assistance, especially during the first 3 to 12 months, to readjust to a lifestyle that is free of both maintenance medication and substances of abuse.

CONTINUING CARE PHASE (**Generativity vs. Stagnation**)

- Follows successful tapering and readjustment. Treatment at this stage comprises ongoing medical follow up by a primary care physician, occasional check-ins with an OTP counselor, and participation in recovery groups. Ongoing treatment, although less intense, often is necessary because the chronic nature of opioid addiction can mean continuous potential for relapse to opioid abuse for some patients.

Treatment Improvement Protocol (TIP) Series, No. 43.
Center for Substance Abuse Treatment.
Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005.

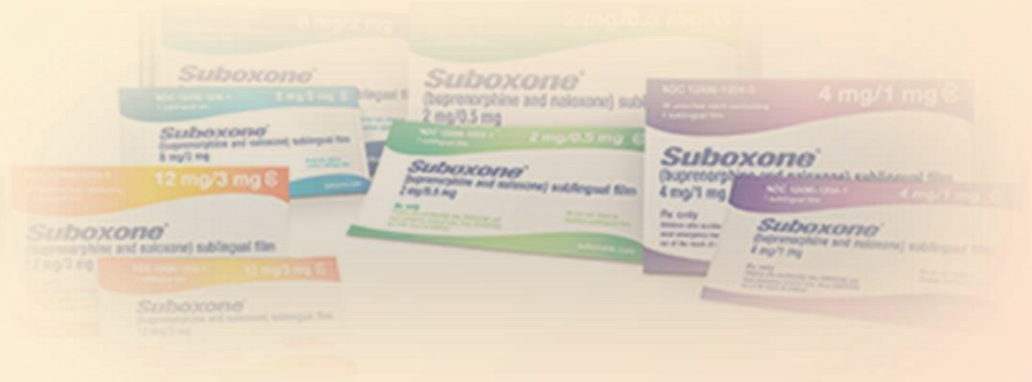

OPEN

Starting Your Buprenorphine Clinic

- Getting your Waiver
- Treatment Guidelines
- Resources
- Developing relationships with Behavioralists

What is DATA?

- Drug Addiction Treatment Act of 2000
  - Allows qualified providers to treat drug addiction with Schedules III-V narcotic controlled substances approved by the FDA for that purpose (Methadone, Buprenorphine)

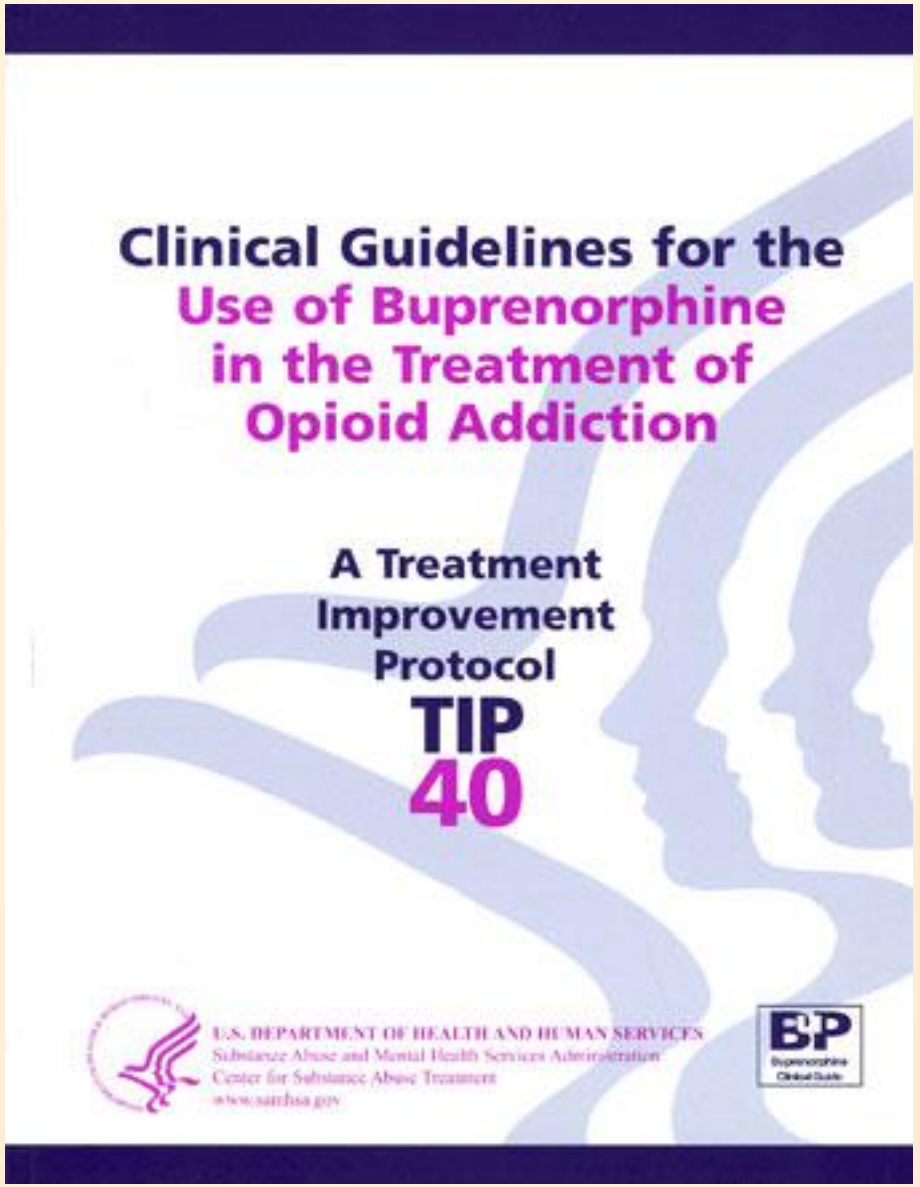


Waiver Training Resources

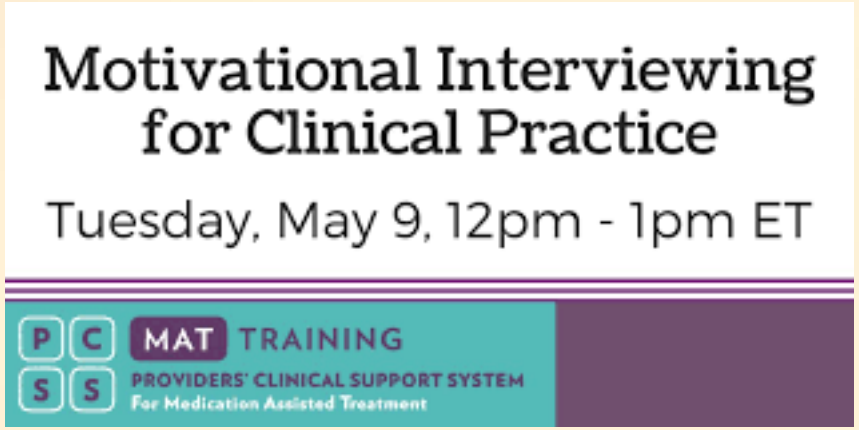
- http://pcssmat.org/education-training/mat-waiver-training/
- https://www.asam.org/education/live-online-cme/buprenorphine-course
- http://www.aaap.org/education-training/buprenorphine/

Reimbursement

	Molina	UHC	Presbyterian
99203 (new patient, intake)	$93.52	$100.07	$100.06
99213 (induction, follow ups)	$50.52	$54.06	$54.05
80305 (optical assay UDS)	$11.55	$12.36	$12.36


Clinical Guidelines for the
Use of Buprenorphine
in the Treatment of
Opioid Addiction
A Treatment
Improvement
Protocol
TIP
40
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov
BTP

Providers' Clinical Support System - MAT



- Clinical Resources
- Webinars
- Mentors
- CME Calendar
- Online Modules

http://echo.unm.edu/

Trust but Verify

- Treatment Agreement
- Counseling Compliance

Opioid Use Disorder Treatment Agreement

Patient: Sue Jones
Practice: Steve Michael, MD, Anderson Health Center, West Haven, Michigan **Date:** 01/18/2015

In order to provide sufficient support for patients in this opioid treatment program, patients need to be aware of and follow our opioid treatment policies. Please review the following patient expectations and signify your understanding and agreement to follow these policies by signing below.

Office Policies

Policies for Appointments

- I agree to keep my scheduled appointments.
- I understand that the following behavior also will not be tolerated more than once:
  - Arriving intoxicated for appointments
  - Disruptive behavior
  - Sustained payment problems

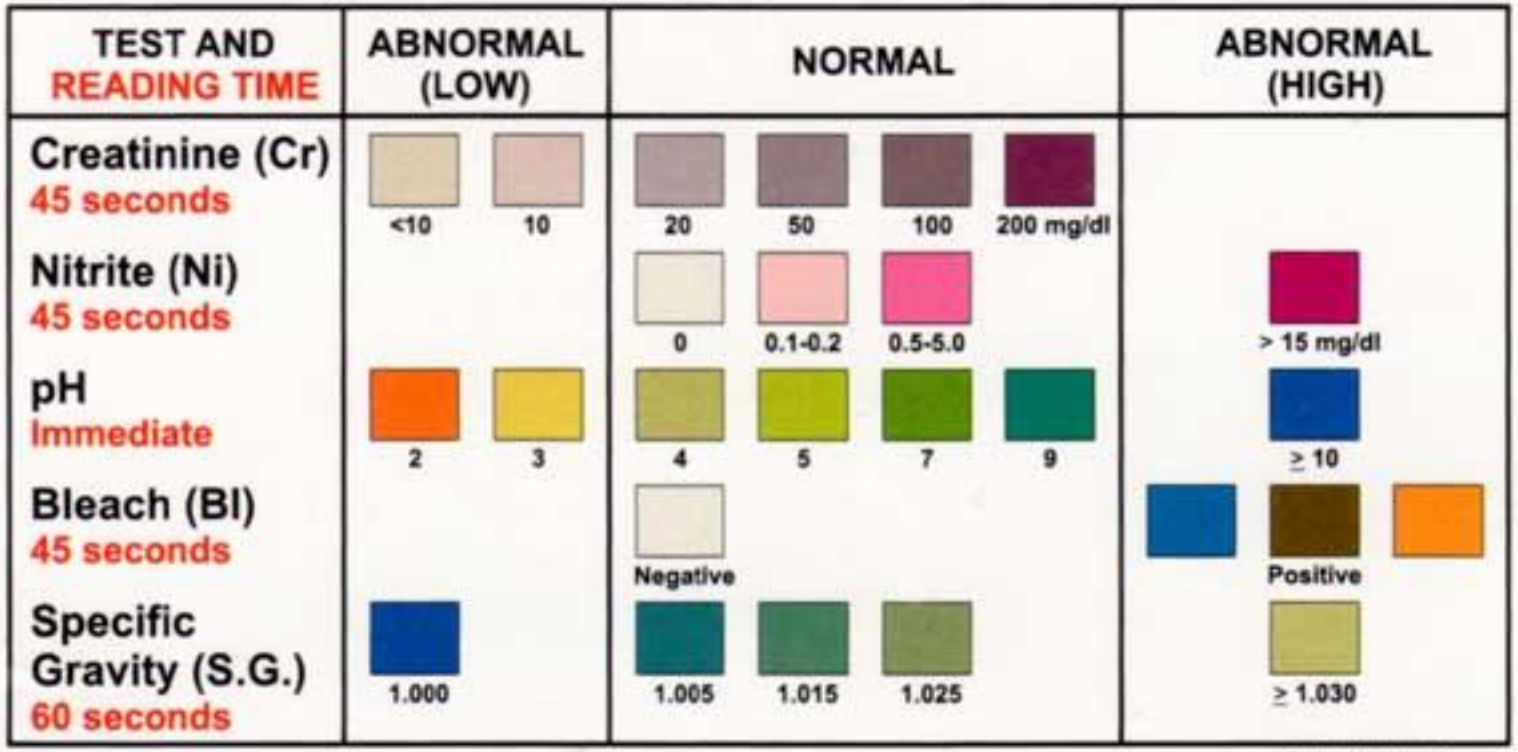
Opioid Treatment Policies Agreement:

The policies in this document have been reviewed with me in person and I have had the opportunity to ask questions. I have been given a written copy. I understand that they may be modified later in order to help provide me with the support needed for successful treatment. My signature signifies my understanding of the policies and my agreement to follow them.

Patient Signature _____ **Date**: _____

Provider_____ **Date**: _____

ADULTERATION COLOR COMPARISON CHART



P/N: 88003-Rev2


Addiction Counseling
Buprenorphine
Family Counseling
Counseling for Comorbidities
Job Training/Skills Development

Summary

- It is necessary to develop policies to prevent further destruction regarding opioid misuse, addiction and death
- Rural Family Medicine providers are on the frontline and Buprenorphine is tool that is easy to use and for patients to access to combat the epidemic of those currently addicted
- New Mexico is rural and one of the pack leaders for number of narcotic related deaths in the nation
- It really is the best part of my clinic day

REFERENCES

- 1. The 5th Vital Sign and America's Painkiller Epidemic. Will Humble, MPH. April 2, 2016. The Healthy Dose, Updates from the experts at the UA Health Sciences. uahs.arizona.edu/blog/2016-04-02/5th-vital-sign-and-america's-painkiller-epidemic
- 2. Stemming the Tide of Prescription Opioid Overuse, Misuse and Abuse. Samantha DuPont, Athan Bezaitis, and Murray Ross. healthaffairs.org/.../stemming-the-tide-of-prescription-opioid-overuse-misuse-and-abu...
- 3. Addiction doc says: It's not the drugs. It's the ACEs – adverse childhood events. May 2, 2017*By* Jane Ellen Stevens *in* ACE Study, Adverse childhood experiences, Child trauma, Community prevention programs.
- 4. Rural Opioid Use Disorder Treatment Depends on Family Physicians. One Pagers | Oct 03, 2016 Peter Wingrove, BS; Brian Park, MD, MpH; and Andrew Bazemore, MD, MpH
- 5. Office-based Treatment of Opioid Dependence with Buprenorphine: Follow-up Q & A Webinar with Case Discussions. David A. Fiellin, MD. (source for slide 14)
- 6. Buprenorphine Outpatient Outcomes Project: Can Suboxone be a viable outpatient option for heroin addiction? Charmain D. Sittambalm, MD, Radhika Vij, MD, and Robert P. Ferguson, MD. Journal of Community Hospital Internal Medicine Perspectives 2014, 4: 22902.
- 7. Treatment Improvement Protocol (TIP) Series, No. 43. Center for Substance Abuse Treatment.Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005.