Assisting Patients With Opioid Addiction Treatment: Slaying the Dragon With Buprenorphine

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This CME session is supported by an educational grant to the AAFP from Indivior.

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Dr. Pentin earned a medical degree from the Jefferson Medical College (now the Sidney Kimmel Medical College) at Thomas Jefferson University, Philadelphia, Pennsylvania, and completed her family medicine residency at the University of Vermont, Burlington. She practices full-spectrum family medicine, including hospital medicine and obstetrics. In addition to being a faculty member at the UW Family Medicine Residency, Seattle, she leads the core clerkship in family medicine for third-year medical students. Dr. Pentin has many years of experience in chronic pain management and the treatment of addictions, particularly opioid use disorder. She is a licensed buprenorphine/Suboxone prescriber. She serves as the primary care pain and addictions expert for the UW Department of Anesthesiology and Pain Medicine, and appears weekly on camera via the UW Telepain consultative service for physicians throughout the Pacific Northwest. In addition, Dr. Pentin is in her 25th year of combined active duty and reserve service as a U.S. Navy medical officer and chairs the Washington Academy of Family Physicians' Annual Scientific Assembly.

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Learning Objectives

1. Consider the benefits and challenges to becoming a waived buprenorphine physician.
2. Describe the DEA registration process required to obtain prescribing privileges for buprenorphine.
3. Become familiar with buprenorphine medications for treatment of opioid dependence.
4. Develop an action plan to decide when to provide office-based opioid addiction treatment vs. referral coordination with treatment specialist.

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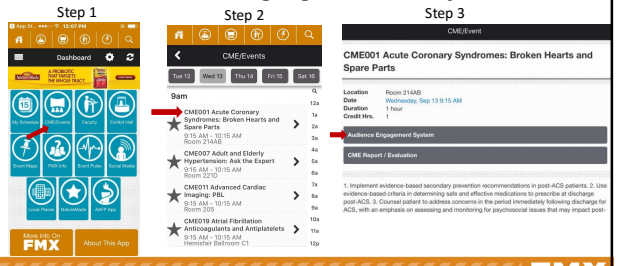
Audience Engagement System



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AES Poll Question -- Who Are We?

A. I have a buprenorphine waiver and currently prescribe for opioid addiction

B. I have a buprenorphine waiver but I don't prescribe for opioid addiction

C. I don't have a waiver

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Joy and Fulfillment in Practice

The treatment of opioid addiction with buprenorphine is an *exceptionally rewarding* part of my practice as a full-spectrum family doctor, and it has never overwhelmed me or my staff.

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You Already Know How to Do It

Like treating all the other addictions you manage as a family doctor every day….

Food
Alcohol
Nicotine
Gambling
Etc.

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What is *Opioid Addiction*?

Dependence

vs

Addiction

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Opioid Use Disorder – DSM-5

Problematic pattern of opioid use leading to clinically significant impairment or distress, manifested by 2 or more of the following in a 12-month period:

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Opioid Use Disorder – The Elements

Taken in larger amounts or longer than intended

Persistent desire or unsuccessful efforts to cut down

Great deal of time spent in activities necessary to obtain the opioid, use it, or recover from its effects

Craving or strong urge to use

Recurrent use resulting in failure to fulfill major obligations at work, school or home

Continued use despite having persistent/recurrent social or interpersonal problems caused or exacerbated by the effects of opioids

Important social, occupational or recreational activities are given up or reduced because of opioids

Recurrent use in physically hazardous situations

Continued use despite knowledge of physical or emotional problem caused by or exacerbated by substance.

*Withdrawal****

Tolerance***

***Symptoms while taking solely under medical supervision is an exception to these criteria

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Chronicity

Opioid use disorder is a chronic, relapsing illness.

Medication-assisted therapy (MAT) is much more effective than abstinence-based therapy.

AES Poll Question

There is a methadone maintenance clinic located within 50 miles of my primary site of practice.

A. Yes

B. No

Medication-Assisted Treatment (MAT)

- Methadone
- Buprenorphine
- Naltrexone (for mild OUD)

Opioid Agonists

Suppress cravings
Prevent withdrawal
By maintaining high level of tolerance, reduce acute euphoric effects other drugs
Reduce spread of HIV and hepatitis
May reduce criminal behaviors
Reduce mortality
Allow return to a productive lifestyle

Levels of Addiction Services

Outpatient, including office-based buprenorphine and methadone clinics

Intensive outpatient

Residential/Inpatient

Medically managed inpatient – dual diagnoses, significant underlying medical comorbidities

History Dictates Intensity of Services Needed

Polysubstance addictions
Dual psychiatric diagnoses
Previous failed treatment attempts
Safety of recovery environment
Readiness for change
Comorbid medical illnesses

Buprenorphine

Sublingual tablet or film
With or without Naloxone – buprenorphine-naloxone/buprenorphine

Partial opioid agonist
Very high affinity for mu receptors, can displace full agonist opioids and precipitate florid withdrawal
Requires brief period of abstinence before starting

Schedule III drug
Out-of-pocket cost of Suboxone about $500/month

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Buprenorphine Adverse Effects

Sedation
Headache
Nausea
Constipation
Insomnia
Respiratory depression +/-

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buprenorphine-naloxone vs buprenorphine

Buprenorphine mixed with naloxone in ratio of 4:1
Naloxone is not absorbed SL or PO – so it passes through inert
Present in buprenorphine-naloxone only to prevent misuse by crushing, dissolving and injecting.
Naloxone will reverse the effects of buprenorphine if injected

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Induction

Typical starting dose 2-8 mg, then observe and re-dose PRN

But in practice, most patients have obtained on the street and already know the dose they need to feel "normal"

Consider Rx several doses with instructions to titrate to stabilization of symptoms. Patients can snip films, cut pills in half.

Return visit 48 hrs, then 1 week. Consider weekly, then possibly extending to longer intervals.

Most will stabilize on 8-16 mg/day, dosed once or twice a day.

"Ceiling effect" at 32 mg/day.

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Maintenance

Remember you are managing a chronic disease
Prescriptions only with office visit
Review new medical issues and stressors since last visit
Review buprenorphine efficacy and side effects
Openly discuss relapses (or almosts)
"Let's look at your notebook"
Consider ongoing benefits of counseling and 12-steps
Eventually may *consider* a dose taper – but not essential

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Who Is a Good Candidate?

Desire for sobriety vs just staying out of withdrawal
Relatively safe and stable living environment
Ability/willingness to pursue sobriety plan aside from just taking replacement medication

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What About Patients With Addiction and Chronic Pain?

In a large U.S.-based health system, 26% of patients prescribed opioids for chronic non-cancer pain met criteria for OUD

Boscarino, JA, Rukstalis, M, Hoffman, SN, Han, JJ, Erlich, PM, Gerhard, GS, Stewart, WF (2010), Risk factors for drug dependence among outpatients on opioid therapy in a large US health-care system. Addiction, 105: 1776-1782.

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Chronic Pain and OUD

Pain treatment with opioids IS NOT effective in the setting of active addiction

Addiction to opioids requires treatment – not just more opioids

Prescribing opioids to addicts contravenes the law, unless in the context of buprenorphine for OUD (or a methadone clinic)

So consider OUD treatment, with addiction as primary goal, pain management may be secondary benefit

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Buprenorphine Success

Two approaches:

Harm reduction model – may be suitable for large practices with multiple prescribers, with extensive onsite staff, social work and behavioral health assets in place

Adjunctive treatment model – may be suitable for individual/small practice-based prescribers, or those providing just as one component of full-spectrum family practice

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Sobriety Commitment

You can individualize to YOUR practice needs and style

DEA seems to have intended buprenorphine to be prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs

My practice and style fits with:

1. Abstinence plan
2. Counseling commitment
3. 12-step meetings

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So How to Do This?

- 30-40 min initial appts – train front desk staff to be on the lookout for patients seeking buprenorphine
- No such thing as buprenorphine "emergency"
- Encourage the patient to bring a trusted friend or family member
- 15-20 min F/U appts
- Full medical, surgical, family and social history, full ROS
- Targeted physical exam – don't forget to document the psychiatric exam
- Urine toxicology screening
- Check your state's PMP, there are often surprises

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Other Helpful "Mechanics"

All-staff meetings to discuss assumptions and misperceptions of who OUD patients are

Rooming details and MA "script" for check-in

Create process for obtaining urine samples

PMP checks

Leave *judgment* at the door

Recognize when a patient may be beyond your abilities as a generalist

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Obtaining A History

Tell me about your drug use
How much do you need to use to feel normal?
How long can you go between using without feeling sick?
When and how much do you need to use to relieve stress?
When did you *have* to transition to heroin?
What other drugs do you use just sometimes?
Have you had to give anything up because of your use?
What previous treatments did you try in order to get clean?
What are your thoughts about getting clean?

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Physical Exam

Chronic Use	Acute Intox or Withdrawal
Track marks	Miosis/Mydriasis
Heart murmurs	Drowsiness
Cervical adenopathy	Yawning
Hepatomegaly	Rhinorrhea

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Patient Education

Encourage patients to take notes, or you jot notes for them

Pharmacology of buprenorphine (many misconceptions from the street)
-side effects
-use with illicit substances
-acute pain management

Your treatment plan and requirements
Duration of therapy
Leave lots of time for questions

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AES Poll Question

A complete urine toxicology screen should be obtained at the first visit with every prospective buprenorphine patient.

A. True
B. False

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Urine Toxicology

May need special assay to detect buprenorphine

Point-of-service testing not essential – this isn't an exercise in "gotcha!"

There will *always* be opioid metabolites on-board when we induce to buprenorphine

Consider obtaining a urine at every visit, and sending periodically

Collaborate with your lab medicine physician colleague

Of questionable safety – Buprenorphine plus alcohol, benzodiazepines, barbiturates

What to do with aberrant results?

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Counseling

ANY counselor can be helpful

Drugs or alcohol certification not critical
Network with your local BH providers to discuss team plan to care for these pts

In resource-poor areas, consider clergy, student-counselors, hospital social worker if patient is willing

Frequency should be what makes sense for the patient

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12-Step Meetings

AA, NA, Methadone Anonymous

Many different group flavors and constituencies

AA may have more structure and stronger spiritual base than NA

Frequency should be what makes sense for the patient

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Educate Your Colleagues

What should your ED do if one of your patients presents having run out of buprenorphine?

How should your ED manage acute pain in patients on buprenorphine?

Consider discussing planning in pieces, over time, at hospital medical staff meetings

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AES Poll Question

The best evidence supports tapering buprenorphine slowly to off following 6-12 months of maintenance therapy.

A. True
B. False

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Duration of Therapy

Short-term treatment with rapid taper associated with high risk of relapse (80+%)

Long-term (years) maintenance therapy generally indicated

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Coding and Billing – E/M Time-Based

New Pt: 99203 – 30 mins *or* 99204 – 45 mins
Est Pt: 99214 – 25 mins *or* 99215 – 40 mins

"I spent _ minutes face-to-face with this patient, greater than 50% of which was spent counseling and coordinating care regarding the management of opioid use disorder."

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Coding and Billing – E/M Medical Complexity

Document and code for comorbid conditions that complicate care:

Other concurrent substance use disorders
Depression, anxiety, personality disorders
Chronic pain diagnoses
Chronic liver and kidney disease
Conditions requiring medications that may interact with buprenorphine

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Coding and Billing – E/M Medical Complexity

Example of assessment:

"Opioid use disorder, severe, in the context of untreated borderline personality d/o, active alcohol abuse, longstanding active Hepatitis C with cirrhosis with known coagulopathy, and sickle cell anemia, requiring frequent ED visits for pain crises."

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Coding and Billing - ICD-10

F-codes = Mental, behavioral, neurodevelopmental disorders

F11.2 Opioid dependence
F11.21 Dependence in remission
F11.22 Dependence with intoxication
F11.23 Dependence in withdrawal

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Indications for Referral to Addiction Specialist

Comorbid chronic pain requiring opioid therapy***

Concurrent alcohol or benzodiazepine dependence

Uncontrolled/unstable concurrent psychiatric disorder

Previous multiple failures of office-based treatment

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For Patients Who Are Not Good Candidates for Buprenorphine

Consider a naloxone Rx
Consider referral to higher level of care
Please manage their comorbidities
-Screen for HIV, Hep B/C, GC/CT, Pap
-Manage other chronic disease
-Discuss contraception – maybe just Rx 'Plan B'
Everyone needs a family doctor

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Managing Acute Pain in Patients on Buprenorphine

Up-titrate SL buprenorphine – max 32 mg/day, dose q 6 hrs (and you don't need a waiver to prescribe in the hospital)

Use short-acting traditional opioids – IV morphine, PO oxycodone – but higher doses required to displace buprenorphine from mu receptors, and caution for OD (have naloxone at bedside)

Non-opioid therapies: local blocks, topical lidocaine, Ketorolac, acetaminophen

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Use in Pregnancy

Methadone still *gold standard*

Where methadone not available or doesn't fit, buprenorphine is a good choice

Less frequent and less intense NAS in baby

Pregnancy Risk category C

Breastfeeding is OK

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Obtaining a Waiver Is Easy Peasy

8 hours of training (1/2 and 1/2 OK) then apply to DEA for waiver

Must be able to attest to capacity to refer patients for counseling and social services

30 patients max first year -> 100 -> 275

Exception to waiver rule:

Hospital physician may bridge a patient already on maintenance during their inpatient hospitalization

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Obtaining Waiver – APP's

2016 legislation signed allowing PA's and NP's to obtain waiver by completing 24 hours of required training (8 + 16)

Implementation is in the works now

Up to 30 patients

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Where to Obtain Training

American Society of Addiction Medicine, American Psychiatric Association, American Academy of Addiction Psychiatry, American Osteopathic Academy of Addiction Medicine

Now all joined into one collaborative effort:

Provider's Clinical Support System for Medication-Assisted Treatment - http://pcssmat.org – ***THE TRAINING IS FREE!***

Also free PCSSMAT online mentoring program - - via phone, email or in person

http://pcssmat.org/mentoring/mentor-directory

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Buprenorphine Implants

- Long-acting subdermal implant
- Low steady dose of medication for 6 months
- FDA-approved 2016
- Only for pts already stabilized on SL buprenorphine
- Requires in-person insertion training program

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Practice Recommendations

1. Office-based treatment of OUD with buprenorphine is like managing the other addictions family doctors are experts at treating.
2. Think outside the box for behavioral health resources in remote and disadvantaged communities.
3. In-house urine toxicology screening is not essential to prescribing buprenorphine.
4. Your patient will tell you what's in their urine at the first visit.
5. The training for a buprenorphine waiver is 8 hours, FREE, and there is FREE mentorship available from http://pcssmat.org.

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Questions

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Contact Info

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Please email me with questions, thoughts and ideas!

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