



Body System: Psychogenic		
Session Topic: Assisting Patients with Opioid Addiction Treatment		
Educational Format		Faculty Expertise Required
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. <u>Please describe your interest and plan for teaching a PBL on your proposal form.</u>
Professional Practice Gap	Learning Objective(s) that will close the gap and meet the need	Outcome Being Measured
<ul style="list-style-type: none"> • New CDC Guideline for Prescribing Opioids for Chronic Pain – physicians need to become aware • Physicians often lack knowledge of new FDA approved abuse-deterrent formulations of pain medications. • Only 3.6% of family physicians have obtained DEA authorization to prescribe buprenorphine. • A key barrier to providers prescribing buprenorphine is their perception that they are unable to provide adequate counseling or psychosocial support to patients with opioid addiction. • Knowledge gap regarding tools to aid in the assessment of patients they suspect of having addictive behaviors. In the event that patients require referral to sub-specialists for more 	<ol style="list-style-type: none"> 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. 	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.



comprehensive screening, evaluation and/or treatment, family physicians should remain the coordinators of patient care.		
ACGME Core Competencies Addressed (select all that apply)		
X	Medical Knowledge	Patient Care
X	Interpersonal and Communication Skills	Practice-Based Learning and Improvement
	Professionalism	Systems-Based Practice
Faculty Instructional Goals		
<p>Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.</p> <ul style="list-style-type: none"> • Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations • Facilitate learner engagement during the session • Address related practice barriers to foster optimal patient management • Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the <u>References</u> section below are a good place to start <ul style="list-style-type: none"> ○ Visit http://www.aafp.org/journals for additional resources ○ Visit http://familydoctor.org for patient education and resources • Explain the benefits and challenges to becoming a waived buprenorphine physician. • Explain the DEA registration process required to obtain prescribing privileges for buprenorphine. • Provide an overview of buprenorphine medications for treatment of opioid dependence, including indications for use, efficacy, and risks. • Provide specific strategies for developing an action plan to decide when to provide office-based opioid addiction treatment vs. referral coordination with treatment specialist. • Provide recommendations regarding guidelines for Medicare reimbursement. • Provide recommendations to maximize office efficiency and guideline adherence to the diagnosis and management of opioid addiction. • Provide an overview of newly available treatments, including efficacy, safety, contraindications, and cost/benefit relative to existing treatments. 		

Needs Assessment

Data from the Centers for Disease Control and Prevention (CDC) reveals that deaths from unintentional drug overdoses in the United States have been rising steeply since the early 1990s and are the second-leading cause of accidental death, with 27,658 such deaths recorded in 2007.¹ That increase has been propelled by a rising number of overdoses of opioids, which caused 11,499 of the deaths in 2007—more than heroin and cocaine combined, and second only to



motor vehicle crash deaths among leading causes of unintentional injury death.^{2,3} Visits to emergency departments for opioid abuse more than doubled between 2004 and 2008, and admissions to substance-abuse treatment programs increased by 400% between 1998 and 2008, with prescription painkillers being the second most prevalent type of abused drug after marijuana.¹ Although both per capita opioid sales and death rates from the drugs vary widely among the 50 states, studies have found a strong correlation between states with the highest drug-poisoning mortality and those with the highest opioid consumption; per capita sales are most strongly linked with methadone- and oxycodone-related mortality.² In contrast, although rates of suicide caused by drug overdoses have also increased somewhat and chronic pain remains a risk factor for depression-linked suicide, the majority of opioid-overdose deaths are accidental. More often than not, laboratory tests reveal the presence of one or more substances in addition to the opioid, suggesting that the depressant effects of alcohol or other drugs on the central nervous system were additive with those of the pain reliever in causing death.⁴

Reducing deaths from opioid overdoses is challenging because such deaths stem from factors that reside both with the patient and the treating physician.² Patient factors often relate to the addictive nature of opioids and thus include misuse or abuse of drugs, “doctor shopping” to obtain multiple prescriptions, and diversion of opioids leading to illicit sales and abuse. In addition, patient sharing of their pain pills with relatives or friends, with little regard for the consequences is common.^{2,5} Much of the risk associated with opioid use also comes through patients making mistakes that put them at grave risk. Patients may be driven to misuse opioids by their desire for greater pain relief or to self-medicate comorbid mental health problems or other issues.⁵⁻⁹ However, family physicians have the potential to be at the forefront of combating this problem. Based on the growing implementation of the patient centered medical home (PCMH) model for patient care,¹⁰ many of these physicians have at their disposal the multiple patient touch points needed to facilitate appropriate drug selection, follow-up, and monitoring that will tailor therapy for an individual as well as identifying and eliminating sources for opioid abuse/misuse.

Data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment Survey indicate that family physicians have a statistically significant and meaningful gap in knowledge and skills necessary to manage patients with substance abuse and addiction problems, including the utilization of risk evaluation mitigation strategies (REMS).¹¹ More specifically, CME outcomes data from 2012-2015 AAFP FMX (formerly Assembly): *Abuse and Addiction*; *Chronic Pain*; and *Opioid Prescribing* sessions suggest that physicians have knowledge and practice gaps with regard to having an awareness of abuse and addiction, including screening recommendations; recognizing one’s own biases regarding addiction patients; use of cognitive behavioral and/or motivational interviewing techniques; utilization of urine drug testing for monitoring; thorough and appropriate documentation; effective use of pain contracts; having an awareness of new treatments and guidelines; having an understanding of ER/LA opioid REMS; and using a stepwise approach to pain management and using state prescription monitoring programs.¹²⁻¹⁵

Additionally, while buprenorphine is an effective medication for opioid use disorder that can be provided in office-based settings, only 3.6% of family physicians have obtained DEA authorization to prescribe buprenorphine via a Drug Addiction Treatment Act of 2000 (DATA



2000) waiver, resulting in more than 30 million people living in counties without access to this treatment.^{16,17} As such, physicians should keep up to date on new FDA approved medications and devices for office-based opioid addiction treatment, to reverse opioid overdose, and associated new warnings. Including, but not limited to the following examples:¹⁸

- Suboxone is a combination of two currently marketed medications, buprenorphine and naloxone. It will be used for the treatment of subjects with heroin and opiate addictions. Suboxone and Subutex were the first therapies approved for in-office prescribing under the federal Drug Addiction Treatment Act of 2000.
- Butrans is a transdermal patch formulation of buprenorphine. Buprenorphine is a partial agonist at mu opioid receptors, an antagonist at kappa opioid receptors, an agonist at delta opioid receptors, and a partial agonist at ORL-1 (nociceptin) receptors.
- Zubsolv is a sublingual tablet formulation of buprenorphine, an opioid analgesic, and naloxone, an opioid antagonist. It was designed to counteract the high effect that may arise following the intravenous injection of a dissolved tablet. Combining buprenorphine and naloxone in a single tablet reduces the risk of intravenous abuse.
- Bunavail buccal film contains buprenorphine and naloxone. Buprenorphine is a partial agonist at the mu-opioid receptor and an antagonist at the kappa-opioid receptor. Naloxone is a potent antagonist at mu-opioid receptors.
- Belbuca buccal film contains buprenorphine, a partial opioid agonist. Belbuca is specifically indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Physicians may improve their care of patients with drug abuse and addiction by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:¹⁹⁻²⁵

- Rapid screening for substance misuse or substance use disorders can be performed in the primary care setting with a validated single-question screening tool.
- Patients with hazardous substance use or substance use disorders may benefit from brief counseling by their primary care physician.
- Systematic review for alcohol; randomized controlled trial and before-after study for other substance use
- Office-based pharmacotherapy for opioid dependence using buprenorphine is safe and effective.
- Patients with substance use disorders may benefit from identification and treatment of comorbid psychiatric disorders.
- Patients with substance use disorders should be routinely screened for intimate partner violence.
- Cultural and ethnic factors affect patterns of substance misuse and treatment response in adolescents who use substances.
- Screening for substance use is recommended for all adolescents.
- Motivational interviewing is effective in adolescents.
- Primary care treatment for adolescent substance abuse should occur in conjunction with treatment from psychiatrists or other mental health experts.



- Immunoassay tests are the preferred initial test for urine drug screening.
- Positive results from an immunoassay test should be followed by gas chromatography/mass spectrometry or high-performance liquid chromatography.
- An extended opiate panel is needed to detect commonly used narcotics, including fentanyl (Duragesic), hydrocodone (Hycodan), methadone, oxycodone (Roxicodone, Oxycontin), buprenorphine, and tramadol(Ultram).
- Appropriate collection techniques and tests of specimen integrity can reduce the risk of tampering.
- At dosages greater than 2 mg per day, buprenorphine maintains treatment retention better than placebo. At 16 mg or more per day, buprenorphine was found to reduce illicit substance use compared with placebo as monitored by urinalysis.

Additionally, physicians should be aware of current AAFP substance abuse and addiction policies, generally summarized as follows:²⁶

- Recognition of the gravity, extent, and broad-based nature of substance abuse and addiction in our society, including the development of novel mechanisms to ingest medications and alcohol;
- Inclusion of substance abuse prevention in patient education;
- Early diagnosis, treatment and referral of those struggling with substance abuse and addictive disorders;
- Recognition of the effects of addiction on family members, especially children, offering support and treatment for family members and inclusion of family members in the treatment of the addicted member when possible; and
- Partnering with community resources in the prevention, education and treatment of substance abuse and addiction.
- Advocating for inclusion of and parity for substance abuse treatment in all health care plans;
- Advocating for legislation and governmental policies facilitating the prevention, diagnosis and treatment of substance abuse, including funding for further research into substance abuse;
- Reinforcement of laws and strategies to limit exposure of the population, particularly adolescents and children, to the abuse and misuse of these substances;
- Supporting harm reduction strategies such as bystander naloxone programs, syringe exchange programs, educational programs and policy initiatives to prevent the secondary diseases associated with abuse and addiction.

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.



Physicians also need continuing medical education to understand the differences between Diagnostic and Statistical Manual of Mental Disorders 4th edition (DSM-IV) and the new DSM-V edition, namely the revised chapter of “Substance-Related and Addictive Disorders” which includes substantive changes to the disorders grouped there plus changes to the criteria of certain conditions.²⁷

In their role as primary care providers, they can take measures to help to prevent substance abuse in certain patient populations, particularly adolescents who may be at risk of developing addictive behaviors after early initiation.²⁸ However, physicians often feel inadequately prepared to meet the needs of these patients. In the largest study on how primary care physicians address substance use disorders, less than 20% described themselves as very prepared to identify alcoholism or illegal drug use, and more than 50% of patients with substance use disorders said their primary care physician did nothing to address their substance abuse.²³ Primary care practitioners are often called upon to differentiate between appropriate, medically indicated opioid use in pain management vs inappropriate abuse or addiction; however, primary care providers and their care teams often struggle to balance these risks and benefits with little outside support.^{29,30} The literature suggests that a key barrier to providers prescribing buprenorphine is their perception that they are unable to provide adequate counseling or psychosocial support to patients with opioid addiction.³¹

Research indicates that chemical changes in the brain may most profoundly affect adolescents because their brains are still developing; drug and alcohol use can disrupt critical areas of functioning such as behavior control, judgment, memory, learning and motivation. It can also predispose them to addiction later in life.³² Family physicians can encourage their children and adolescents to participate in science-validated prevention programs, such as: universal programs, which address children in schools or community centers about risks and protective factors; selective programs, which target groups of children and teens who have certain risk factors; and indicated programs, which are designed for youth who have already begun abusing drugs. As the National Institute of Drug Abuse states, “while many events and cultural factors affect drug abuse trends, when youths perceive drug abuse as harmful, they reduce their level of abuse.”³² Similarly designed education programs can also benefit older patients who may be at risk of developing substance abuse disorders.

Addiction to prescription pain relievers, in particular—notably hydrocodone, oxycodone, and morphine—has risen dramatically in recent years; in fact, it is listed as the second most prevalent type of illicit drug use, after marijuana use, among people over the age of 12. The proportion of admissions to substance abuse treatment facilities due to pain medication abuse increased fourfold over a span of 10 years (from 2.2% in 1998 to 9.8% in 2008). Physicians who prescribe pain medication should educate patients on correct dosages, safe storage, and proper disposal of leftover medication; they should also be prepared to identify patients with drug-seeking or addictive behavior and offer resources (i.e., referral to treatment facilities or services) to those with substance abuse problems.³³

Research also indicates that people with mood disorders—particularly bipolar disorder type II—are at significant risk for developing substance abuse problems, suggesting that early detection and interventions for patients with mental health disorders may prevent dependence on alcohol or



prescription medications.^{34,35} Additionally, rates of intimate partner violence exceed 50% in patients with drug use disorders in some settings; it is recommended that physicians screen all patients who present with substance use disorders for intimate partner violence.^{23,36,37}

Family physicians should be aware of recent trends in substance use and abuse in certain patient populations (such as adolescents, young adults, and those with diagnosed psychiatric conditions) in order to be prepared to offer comprehensive treatment plans, often involving a multidisciplinary team approach to care. Family members should also be involved in the treatment of patients with substance abuse, which family physicians are uniquely prepared to coordinate and oversee.

Patients with a confirmed diagnosis of substance abuse typically require treatment that includes behavioral therapy, pharmacologic treatment (such as in the case of withdrawal), and occasionally inpatient or outpatient treatment for detoxification or complications.³² The American Medical Association (AMA)-convened Physician Consortium for Performance Improvement (PCPI) lists the following as performance measures for substance abuse disorders, which are also endorsed by the APA and National Committee for Quality Assurance:³⁸

- Counseling regarding psychosocial and pharmacologic treatment options for alcohol dependence
- Counseling regarding psychosocial and pharmacologic treatment options for opioid addiction
- Screening for depression among patients with substance abuse or dependence.

Such performance measures are intended to foster accountability among health professionals, as well as enhance quality and patient safety. (However, physicians should remember that clinical decisions about patient care should be made on an individual basis.) As family physicians orchestrate care for patients who require referral to or treatment from sub-specialists, they can ensure patients comply with treatment and return to or maintain an optimal level of functioning and overall health.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Rational use of opioids for management of chronic nonterminal pain³⁹
- CDC Guideline for Prescribing Opioids for Chronic Pain⁴⁰
- AAFP Opioid Prescribing for Chronic Pain. Clinical Practice Guideline(s)⁴¹
- A primary care approach to substance misuse²³
- Urine Drug Screening: A Valuable Office Procedure²⁰
- Adolescent Substance Use and Abuse: Recognition and Management¹⁹
- Managing Opioid Addiction with Buprenorphine^{25,42}
- Buprenorphine Maintenance vs. Methadone Maintenance or Placebo for Opioid Use Disorder²²
- VA/DoD clinical practice guideline for management of substance use disorders (SUD)⁴³
- Interagency guideline on opioid dosing for chronic non-cancer pain: an educational aid to improve care and safety with opioid therapy⁴⁴
- Clinical guidelines for the use of chronic opioid therapy in chronic non-cancer pain⁴⁵
- Thinking on paper: documenting decision making⁴⁶
- Engaging Patients in Collaborative Care Plans⁴⁷



- A systematic approach to identifying drug-seeking patients⁴⁸
- How to monitor opioid use for your patients with chronic pain⁴⁹
- Integrating a behavioral health specialist into your practice⁵⁰
- FamilyDoctor.org: Substance Abuse (patient resource)⁵¹
- FamilyDoctor.org: Opioid Addiction (patient resource)⁵²

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