“It’s Not Just One More Thing!”

Overcoming Obstacles for Buprenorphine Treatment by Residents, Faculty and Programs

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Disclosures

• Ken Saffier, MD, has nothing to disclose.

• Maureen Strohm, MD, has nothing to disclose.
Learning objectives

By the end of this session, participants will be able to:

1. Explore and share ways to overcome faculty, resident, program and clinic barriers to buprenorphine treatment.

2. Use video clips of DEA buprenorphine waivered family physicians and clinic staff to motivate colleagues to initiate or expand Medication Assisted Treatments for opioid use disorders.

3. List 1 or 2 commitment to act statements to promote or expand your own practice or your program’s implementation of buprenorphine education and treatment.
Outline for this session:

• Introductions
• What is your understanding about medication assisted treatment for opioid use disorders?
• Patients’ perspectives
• Providers’ perspectives
• What does “support” look like?
• Summary and Conclusions
So nice to meet you

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Overdose Deaths Involving Opioids, United States, 2000-2015

- Any Opioid
- Commonly Prescribed Opioids (Natural & Semi-Synthetic Opioids and Methadone)
- Heroin
- Other Synthetic Opioids (e.g., fentanyl, tramadol)

In 2009

39,147 Americans died from drug poisonings

Nearly 14,800 deaths involved prescription opioids

For every 1 death there are:

10 treatment admissions for abuse
32 ED visits for misuse or abuse
130 people who abuse or are addicted
825 nonmedical users


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National Impact

Prescription Drug Deaths Now Outnumber Traffic Accidents in the U.S.

41,502 + Drug Induced Deaths in 2012 (22,114 from PD’s)

259 Million Painkiller Prescriptions in 2012 (16,007 Deaths)

1.4 Million ED Visits in 2011 for Non Medical Rx Use

91 Opioid Drug Overdose Deaths Every Day

Data Source: CDC
Where Do Drugs of Abuse Come From?

<table>
<thead>
<tr>
<th>Majority of Abusers</th>
<th>Primary Drug Sources</th>
<th>Most Addictions</th>
</tr>
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</table>
| • 70% from Family & Friends  
• Home Medicine Cabinets | • Primary Care Providers (Including Dentists)  
• Emergency Departments  
• Internet Pharmacies | • Begin With Legitimate Mental and Physical Health Issues |
“Opioid Overload: Drug companies sued for flooding West Virginia county with 40 million doses of opioids.” Vice News March 10, 2017
% US primary care MDs received buprenorphine waivers

3%


• 2016 CERA study: 27% programs offered buprenorphine training
Lack of access = Care Denied

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What is your understanding about ____?

• Buprenorphine? And other medical treatments?

• Substance use disorders?

• A support system for bup/nx pharmacotherapy in primary care?
Patients’ perspectives:

• What have been your patients’ experiences?
  – Who take or have taken buprenorphine/naloxone?
  – Who take or have taken methadone?
  – Naltrexone XR?
  – Non-opioid treatments?
• Video – patients’ perspectives
Buprenorphine vs. Placebo for Heroin Dependence
Kakko, Lancet 2003

Even with enriched psychosocial services, all in detoxification group dropped out of study by 60 days, but 80% of the maintenance group were retained in treatment.

4 Subjects in Control Group Died
Human Opioid Receptors $\mu$, $\delta$, and $\kappa$

LaForge, Yuferov and Kreek, 2000

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Dopamine Pathways

- **Functions**
  - reward (motivation)
  - pleasure, euphoria
  - motor function (fine tuning)
  - compulsion
  - perserveration
  - decision making

Serotonin Pathways

- **Functions**
  - mood
  - memory processing
  - sleep
  - cognition

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Buprenorphine:
A brief summary of a unique opioid

- High affinity for the mu opioid receptor
  - Competes with other opioids and blocks their effects
  - Can precipitate withdrawal in highly opioid dependent individuals
- Slow dissociation from the mu receptor
  - Prolonged therapeutic effect for opioid dependence treatment
- “Ceiling effect” for stimulation of a given receptor

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Intrinsic mu Activity: Full Agonist (Methadone), Partial Agonist (Buprenorphine), Antagonist (Naloxone)
Precipitating Withdrawal

- Buprenorphine will precipitate withdrawal when it displaces full agonist off the mu receptors.

![Graph showing the effect of buprenorphine and heroin on mu receptor activity.](image)
What’s so different about Buprenorphine?

• Safe, effective
  – Low side effect profile
  – Low overdose risk
• Flexible, office-based treatment
  – Anonymous
  – Integrated with other forms of medical/psychiatric care
  – Patients control dosing times
    • No “take home” restrictions
    • Impact on work, family travel
Additional medication assisted treatments:

- **Naltrexone XR**
  - Monthly I.M. injections for opioid use disorders (not for bup treated patients)
  - Reduces alcohol craving – oral or injectable

- **Methadone** – (Opioid Treatment Program)
  - Detox, maintenance
Providers’ perspectives

• As very busy providers, in general, what would be your **reasons** to learn a new skill or use a new tool to help your patients?

• And your patients with OUD, in particular?

• What obstacles are there for you personally, your program, clinic, and/or system?
It often feels like -
• Video – providers’ perspectives
Providers’ perspectives (cont’d):

• Getting a DEA waiver for buprenorphine requires 8 hours of additional (‘easy’) training.

• How important is it for you to offer MAT with buprenorphine to your patients with OUDs?

• How confident are you to take a “1/2 and 1/2” waiver course to get your “X number” in the next 2 months?
Hypertension Treatment

Addiction Treatment

Symptom Severity

Stage of Treatment

Pre  During  During  During  During  Treatment  Ends

Stage of Treatment

Pre  During  During  During  During  Treatment  Ends

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Why Opioid “Maintenance”? 

- 80-90% relapse to drug use without it
- Increased treatment retention
- 80% decreases in drug use, crime
- 70% decrease all cause death rate

NIH Consensus Statement, JAMA 1998
What does support consist of?

- Every system is unique but there are common features.

- What barriers do you face?

- What are some of the possible solutions?
• Video – What does support look like?
Primary Care Buprenorphine Programs
10 Elements for Success

• A champion
• Staffing for administrative activities
• A team-based approach
• Connection to behavioral health services
• Mentoring support for physicians

10 Elements for Success (cont’d.)

- Two waived doctors per practice
- Assessment of patient readiness
- An induction approach that fits
- Pharmacists willing to partner
- Sustainable financing

Masters, B., Rainwater, M., 2016, [www.chcf.org](http://www.chcf.org)
An Eleventh Element for Success

- 11. Administrators’ support for all aspects of the above.
What really makes a difference?

A Significant Predictor of Positive Outcome:

A Positive Provider Attitude

Positive Attitudes: Implications for Patient Care

- Increased screening
- Increased diagnoses
- Increased access and referrals to tx
- Improved outcome
- Increased hope – for patients, families, staff

• Video – summary and patient testimonial
Summary and Conclusions

• What are your most relevant “take home” points?

• What can you do by/for yourself to attain your goals?

• What can you do with your team to meet your and your patients’ needs better?
Resources:

- Waiver courses:
  - [www.AOAAM.org](http://www.AOAAM.org) (Education – schedule)
    - “1/2 and 1/2 “ course (free)
- [www.pcssmat.org](http://www.pcssmat.org) (Providers Clinical Support System)
  - Mentorship
  - Modules
  - Webinars
- CA Health Care Foundation: [www.chcf.org](http://www.chcf.org)
- [www.csam-asam.org](http://www.csam-asam.org)
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- STFM program committee

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