The Opioid Epidemic & Medication For Addiction Treatment (MAT) The Time is NOW!

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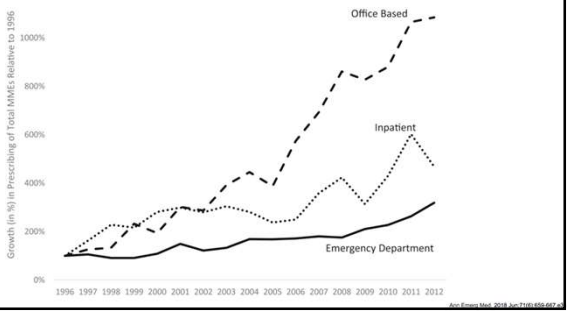
Agenda

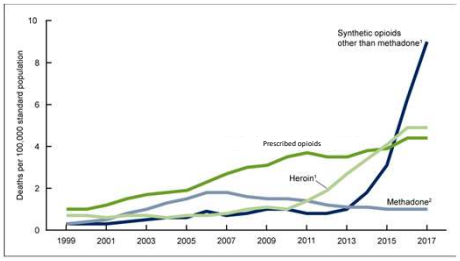
1. Describe the Opioid epidemic and its impact on our practices, communities & country.
2. Explain how to better understand Opioid Use Disorders (Addiction)
3. Demonstrate the compelling science behind MAT & Buprenorphine
4. Describe the law around using Buprenorphine & how it applies to Clinicians.
5. Discuss how we can apply MAT in our practices.

Objective 1: The Opioid Epidemic

Increase in opioid prescribing by practice environment



Annual Overdose Rates by Opioid



72,000 OD DEATHS
47,000 OPIOID OD DEATHS

Current Management of OUD is Medically Inadequate & Negligent

OPIOID OVERDOSE

- Myth: "Opioid withdrawal isn't life threatening"
- FACT: Save em' and Street em'. Ignores the underlying medical emergency & patients die.

OPIOID WITHDRAWAL

- Myth - Clonidine, Bentyl, Ketorolac, Zofran, IVF is good care.
- FACT - Patients go home feeling the same as they come in.

OPIOID USE DISORDER

- Myth: "A choice". "They have to want to change". "Nothing we can do to help".
- FACT: Effective treatments have existed since the 1940's for OUD. We decided not to use them.
- Fact – we have perpetuated and tolerated a broken system of care

Objective 2: Understanding OPIOID USE DISORDER

ADDICT. BAD PERSON. A CHOICE. A MORAL FAILING. WASTE OF TIME

ADDICTION:

ENDORPHINS
DYNORPHINS
DOPAMINE
REWARD
SYSTEM
MALFUNCTION

BRAIN FAILURE

USE TO:
GET HIGH
NORMAL
NOT FEEL SICK

A MEDICAL DISEASE
DRUG SEEKING IS COMPULSIVE. DIFFICULT TO CONTROL.
ADDICTION > CONSEQUENCE.
RELAPSING & REMITTING

Addiction is misunderstood by the medical community & lay press

BABIES CANNOT BE BORN ADDICTED TO AN OPIOD

TABLE 1 Summarized DSM-5 diagnostic categories and criteria for opioid use disorder

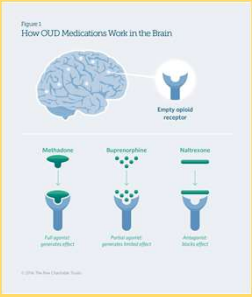
Category	Criteria
Impaired control	• Opioids used in larger amounts or for longer than intended • Unsuccessful efforts or desire to cut back or control opioid use • Excessive amount of time spent obtaining, using, or recovering from opioids • Craving to use opioids
Social impairment	• Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use • Continued opioid use despite persistent or recurrent social or interpersonal problems caused or exacerbated by opioids • Reduced or given up important social, occupational, or recreational activities because of opioid use
Risky use	• Opioid use in physically hazardous situations • Continued opioid use despite persistent or recurrent physical or psychological problem caused or exacerbated by opioids
Pharmacological properties	• Tolerance as defined by either of the following: need for greatly increased amounts of opioids needed to achieve desired effect; or markedly diminished effect with continued use of the same amount • Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal

TAKE HOME

DEPENDENCE ≠ ADDICTION

ADDICTION = DEPENDENCE + DETRIMENTAL BEHAVIORS!

OBJECTIVE 3: THE EVIDENCE BEHIND MAT



Opioid addiction does not respond to the same treatments as alcoholism.

Abstinence based therapies generally DO NOT WORK: ~ 95% relapse rate.

Twelve Step programs have a <5% rate of sobriety at one year, when treating Opioid Use Disorder.

MAT:

Naltrexone

Methadone

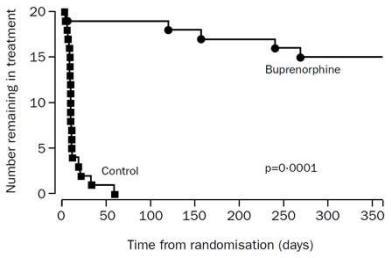
Buprenorphine ("Bupe")

Why Use MAT?

Because	→	***We Can***
• Increased treatment retention	→	Start patients on the right path
• 90%+ relapse without MAT	→	Keep patients healthy
• 80% decrease in drug use, crime	→	Improve our communities
• 60 - 70% decrease in motality	→	Save lives

NIH Consensus Statement et al. *JAMA.* → 1998.

Buprenorphine Maintenance vs Taper Method (Heroin Use Disorder)



Kakko J et al. *Lancet.* 2003

Results

Completion 52 week trial:

- taper = 0%
- maintenance = 75%

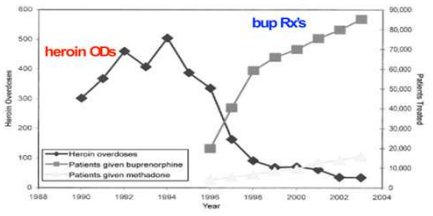
Mortality:

- **Taper = 20%**

In 1996, France responded to its heroin overdose epidemic by training/licensing GP's to prescribe buprenorphine

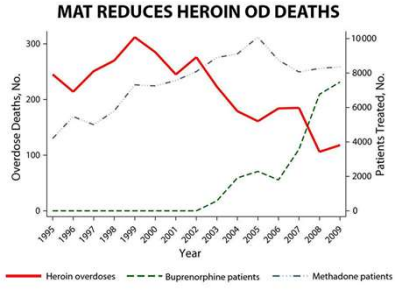
Over 8 years:

- 3x increase methadone treated patients (up to ~15,000 pts)
- 4.5x increase in bupe tx pts (up to ~90,000 pts)
- **90% reduction in heroin overdoses!!**
- **~50,000 pts down to ~5,000 pts!**



Auriacombe, et al, *Am J Addict.* 2004;13 Suppl 1:S17-28.

Heroin overdose deaths and opioid agonist treatment: Baltimore, MD, 1995–2009



~~Medication Assisted Treatment~~
Medication for Addiction Treatment

Cochrane Library
Cochrane Database of Systematic Reviews

Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence (Review)

Amato L., Minozzi S, Davoli M, Vecchi S Cochrane Database Syst Rev. 2011 Oct 5;(10):CD004147

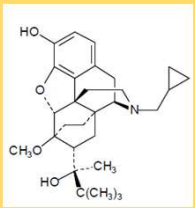
Review specifically studied value added of routine, mandatory counseling sessions in MAT programs

"… adding any psychosocial support to standard maintenance treatments does not add additional benefits."

Characteristics of Medications for Opioid-Addiction Treatment.

Characteristic	Methadone	Buprenorphine	Naltrexone
Brand names	Dolophine, Methadose	Subutex, Suboxone, Zubsolv	Depade, ReVia, Vivitrol
Class	Agonist (fully activates opioid receptors)	Partial agonist (activates opioid receptors but produces a diminished response even with full occupancy)	Antagonist (blocks the opioid receptors and interferes with the rewarding and analgesic effects of opioids)
Use and effects	Taken once per day orally to reduce opioid cravings and withdrawal symptoms	Taken orally or sublingually (usually once a day) to relieve opioid cravings and withdrawal symptoms	Taken orally or by injection to diminish the reinforcing effects of opioids (potentially extinguishing the association between conditioned stimuli and opioid use)
Advantages	High strength and efficacy as long as oral dosing (which slows brain uptake and reduces euphoria) is adhered to; excellent option for patients who have no response to other medications	Eligible to be prescribed by certified physicians, which eliminates the need to visit specialized treatment clinics and thus widens availability	Not addictive or sedating and does not result in physical dependence; a recently approved depot injection formulation, Vivitrol, eliminates need for daily dosing
Disadvantages	Mostly available through approved outpatient treatment programs, which patients must visit daily	Subutex has measurable abuse liability; Suboxone diminishes this risk by including naloxone, an antagonist that induces withdrawal if the drug is injected	Poor patient compliance (but Vivitrol should improve compliance); initiation requires attaining prolonged (e.g., 7-day) abstinence, during which withdrawal, relapse, and early dropout may occur

Outside of OTP's –
BUPRENORPHINE IS OUR TOOL

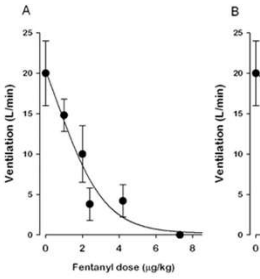


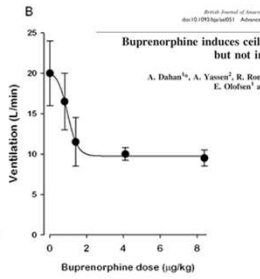
PARTIAL AGONIST

<u>OUR SAFEST OPIOID & TREATMENT MODALITY</u>

COMBINATION DRUG (SUBOXONE) IS TO PREVENT DIVERSION

BUP is SAFE - Ceiling on Respiratory Depression



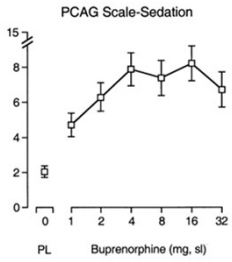


BJA

Buprenorphine induces ceiling in respiratory depression but not in analgesia

A. Dahan[1*], A. Yassen[2], R. Romberg[1], E. Sarton[1], L. Teppema[1], E. Olofsen[1] and M. Danhof[2]

BUP is SAFE: Ceiling on Sedation



ORIGINAL CONTRIBUTION

Effects of High-Dose Intravenous Buprenorphine in Experienced Opioid Abusers

Annie Umbricht, MD,† Marilyn A. Huestis, PhD,* Edward J. Cone, PhD,*† and Kenzie L. Preston, PhD**

In most cases you can give very large doses, 32mg SL and patient will not be significantly obtunded.

Some hospitals will load pts with 32mg SL when doing induction…more on that to come.

Buprenorphine is SAFE

- Highly safe medication (for both acute and chronic dosing)
- No evidence of significant disruption in cognitive or psychomotor performance with buprenorphine maintenance
- No evidence of organ damage with chronic dosing of Buprenorphine "mono" or "combo" formulations

Buprenorphine / Naloxone Products

- Combinations of buprenorphine and naloxone come in tablets or strips
- Naloxone prevents the dissolution and IV injection of buprenorphine.
- "Suboxone," is a 4:1 ratio of Bupe/naloxone.
- Many E.D's doing MAT only generic mono-product Bupe is used.
  - less expensive.
- Not time-released so tablets/film strip can be cut/split

THE SKEPTICS…
"We are trading one addiction for another"

TABLE 51-1 Summarized DSM-5 diagnostic categories and criteria for opioid use disorder

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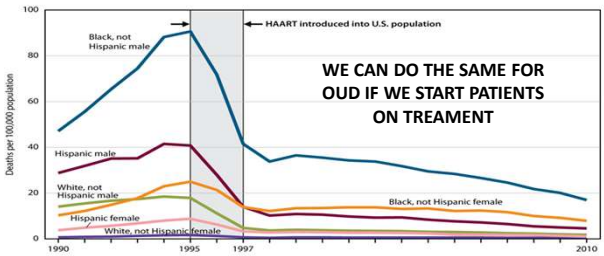
- This is what MAT does…<u>it changes addiction for dependency.</u> Which can be worked on overtime if abstinence from all opioids is the patient's goal.

Death rates for HIV disease for all ages



NOTE: HAART is highly active antiretroviral therapy.
SOURCE: CDC/NCHS, Health, United States, 2013, Figure 24. Data from the National Vital Statistics System.

Objective 4: The Law & Buprenorphine

DATA 2000 & Prescribing Buprenorphine

- Need an X-Waiver to give buprenorphine for addiction treatment
  - 8 hour course for physicians
  - 24 hour course for NP/PA's
- Restrictions on patients / year
  - Year 1: 30 patients / Year 2: 100 patients / After Year 2 – can apply for 275
- Must be in a "qualified practice setting"
  - Access to case management and referral
  - Uses EHR
  - Registered PDMP
  - Accepts 3rd Party payments

http://www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines/special-circumstances-providing-buprenorphine

Acute Care Settings: "3 DAY RULE" 21 CFR. 1306.07(b)

"According to DEA … the "three-day rule" allows a practitioner who is not separately registered as a narcotic treatment program or certified as a waivered DATA 2000 physician, to administer (but not prescribe) narcotic drugs to a patient for the purpose of relieving acute withdrawal symptoms while arranging for the patient's referral for treatment, under the following conditions:

- **Not more than one day's medication may be administered or given to a patient at one time.**
- **Treatment may not be carried out for more than 72 hours**
- **The 72-hour period cannot be renewed or extended"**

http://www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines/special-circumstances-providing-buprenorphine

WHAT YOU NEED TO KNOW

- Any Doc / APP can prescribe Bupe for pain.
- Any Doc / APP can use Bupe in the hospital to treat opioid withdrawal.
- Must have an DEA license "X-waiver" to PRESCRIBE for ADDICTION
  - STRONGLY CONSIDER GETTING YOUR X-WAIVER
  - YOU'LL BE ABLE TO TAKE BETTER CARE OF YOUR PATIENTS
  - YOU WILL BE PART OF THE SOLUTION TO THE OPIOID EPIDEMIC
- Patients can return for 3 days in a row to get Bupe in the ED.

OBJECTIVE 5: Applying Buprenorphine in your practice

Predicate Decisions on Science, Not Fear

"My practice will be awash with drug seekers, trying to get bupe!"

EDs data with bupe shows opioid- seeking patient visits decrease!

If more patients come to your practice hoping to start MAT, would that be a bad thing?

OUD is deadly and highly treatable! Give patients the life saving medications they deserve.

EASY TO DO… "IT's ODT ZOFRAN FOR OUD"

Effective within 15 minutes (sublingual), and peak effects at ~ 1 hour.

Can be done @ HOME

- **SOWs Score & Buprenorphine Prescription for home**

PITFALLS

1. Mild withdrawal patient: Danger of precipitated withdrawal is high!
2. METHADONE in the last 48 hours (not an absolute contraindication):
   - Unpredictable precipitated withdrawal can occur
   - **consult an expert first,** unless pt in severe withdrawal
3. Intoxicated --alcohol, benzodiazepines, stimulants, etc…
   - Unpredictable immediate results.
   - At risk for polypharmacy synergistic respiratory depression, with polydrug use after discharge.

Don't Re-invent the Wheel

1. www.coloradomat.org
2. www.bridgetotreatment.org
3. https://medicine.yale.edu/edbup/
4. www.aafp.org/afp/2018/0301/p313.html

What We Can Offer our Pt's with OUD

Thank you!

Contact Information

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Resources available @

www.coloradomat.org