Navigating Buprenorphine Prescribing for the Primary Care Physician

Module 1

Today's Presenter

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Disclosure

MI-CCSI, or the presenter, does not have any financial interest, relationships, or other potential conflicts, with respect to the material which will be covered in this presentation.

Patient-Centered Treatment for Substance Use Disorder in Primary Care

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Clinical

Module	Title
1	Navigating Buprenorphine Prescribing for the Primary Care Physician
3	Buprenorphine Medical Management: Monitoring the Patient
5	Challenging Clinical Scenarios in MOUD: Early Refills and Lost or Stolen Medication
7	Complex Cases in Buprenorphine Treatment, Part 1
9	Complex Cases in Buprenorphine Treatment, Part 2
11	Pain and Addiction

Operational

Module	Title
2	Substance Use Disorder and Patient Identification
4	OBAT Eligibility, Intake and Assessment
6	Patient Support for Induction and Maintenance
8	Operationalizing Team Meetings, Systematic Case Review, & Documentation
10	Team Roles and Responsibilities
12	Supporting the Patient Beyond Buprenorphine

OBJECTIVES

At the conclusion of this presentation, the participant will be able to:

- **Describe aspects of social and regulatory history that have impacted opioid use.**
- **Recognize challenging clinical scenarios related to buprenorphine.**
- **Recall key principles associated with the diagnosis of opioid use disorder.**
- **Use a patient-centered approach to patient assessment.**

AGENDA

1	Brief Historical Overview
2	Challenging Clinical Scenarios
3	How to Diagnose an Opioid Use Disorder
4	Patient Assessment

Brief Historical Overview

Let’s go back in time and take a brief walk-through history….

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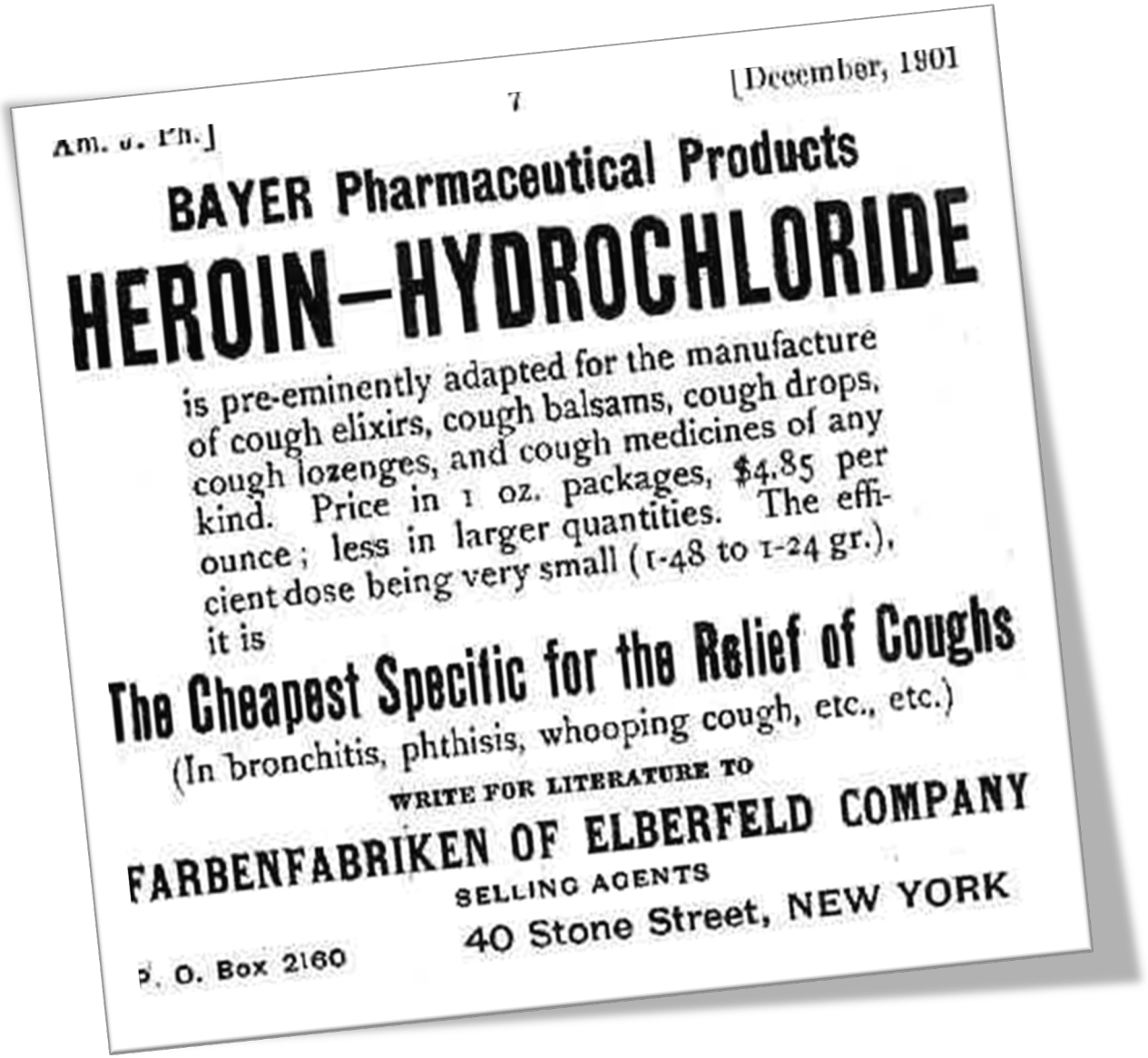
Heroin Advertisement



Am. J. Ph.] 7 [December, 1901

BAYER Pharmaceutical Products

HEROIN—HYDROCHLORIDE

is pre-eminently adapted for the manufacture of cough elixirs, cough balsams, cough drops, cough lozenges, and cough medicines of any kind. Price in 1 oz. packages, $4.85 per ounce; less in larger quantities. The efficient dose being very small (1-48 to 1-24 gr.), it is

The Cheapest Specific for the Relief of Coughs

(In bronchitis, phthisis, whooping cough, etc., etc.)

WRITE FOR LITERATURE TO

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Narcotic Farms Act of 1929

An Act to establish two United States narcotic farms for the confinement and treatment of persons addicted to the use of habit-forming narcotic drugs who have been convicted of offenses against the United States, and for other purposes.

Farm in Lexington is the most well know, although there was also one in Fort Worth, TX.

Lexington Narcotic Farm

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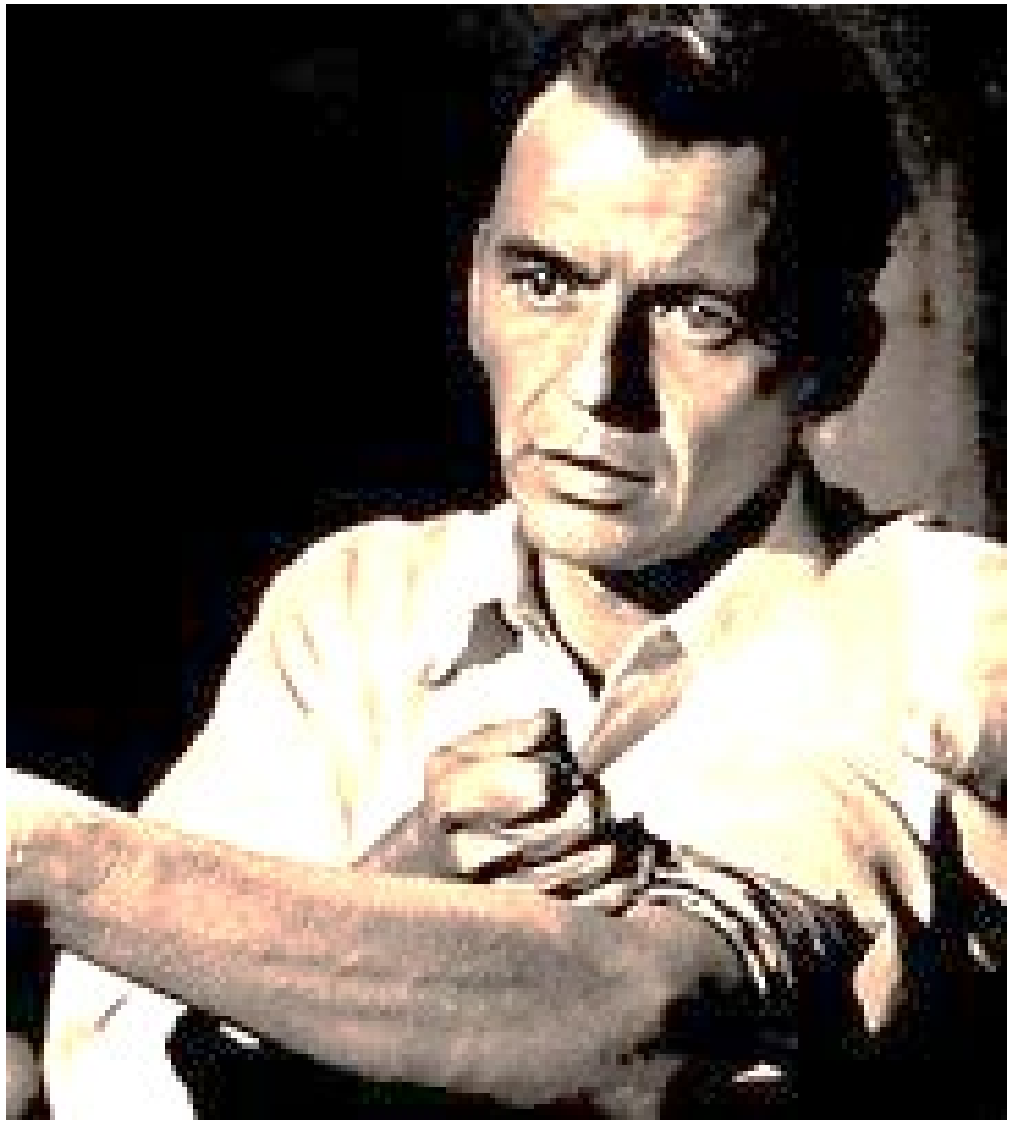
Who is this?

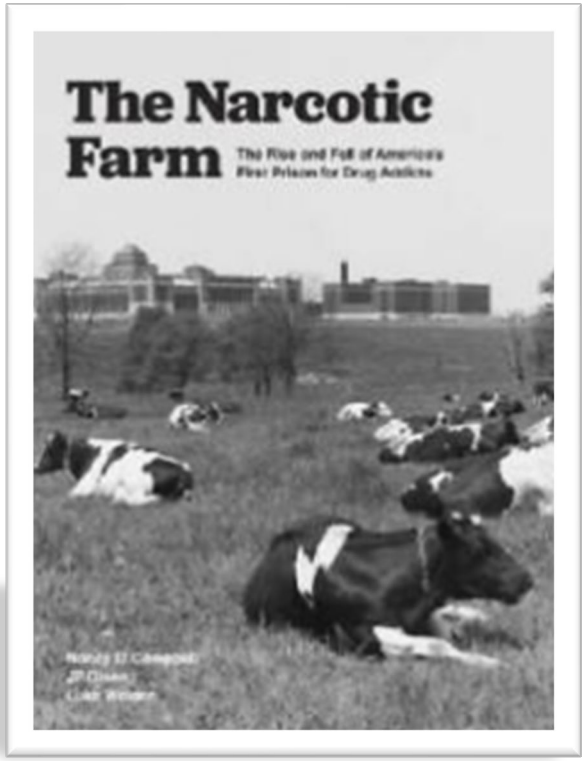
Can you name the movie?



The Man with the Golden Arm (1955)

Excellent Documentary

Available free online



Historical Background

Prior to 2002, the use of opioid medications to treat opioid addiction was permissible only in federally approved Opioid Treatment Programs (OTPs) (i.e., methadone clinics), and only with the Schedule II opioid medications methadone and levo-alpha-acetyl-methadol (LAAM),

which could only be dispensed, not prescribed.

Due to a number of factors, including the association of LAAM with cardiac arrhythmias in some patients, as of January 1, 2004, the sole manufacturer has ceased production of the drug.

Historical Background

Under the **Drug Addiction Treatment Act of 2000 (DATA 2000)** qualifying physicians in the medical office and other appropriate settings outside the OTP system **may prescribe and/or dispense Schedule III, IV, and V opioid medications for the treatment of opioid addiction** if such medications have been specifically approved by the Food and Drug Administration (FDA) for that indication.

In October 2002, FDA approved two sublingual formulations of buprenorphine for the treatment of opioid addiction. These medications were Subutex® (buprenorphine) and Suboxone® (buprenorphine/naloxone).

Challenging Clinical Scenarios

Common Challenges with Buprenorphine Patients

What do I do with?

- Early refill requests.
- Patient reports using more than prescribed.
- UDS is positive for other opioids.
- UDS shows illicit substances, such as cocaine and/or methamphetamine.
- UDS does not show buprenorphine.
- Patient reports regular cannabis use (legal and recreational).
- Patient is struggling with chronic pain and has been on long-term opioid therapy. There is some concerning behaviors, but I'm not sure if this is an addiction. What should I do?

A case discussion always helps bring concepts together…

Case 1

- 43-year-old married female with chronic low back pain has been prescribed oxycodone 30 mg every 6-8 hour for the last 3 years.
- She presents to your office for a refill. Remote EMR data shows a previously unnoticed ER visits 6 months ago at an outside health system for MS status changes. Patient responded to Narcan in ER and was discharged home.
- She reports accidental overdosing on oxycodone by “getting my medications confused.” Patient tells an elaborate story of how her meds are placed in a weekly organizer by her husband, who unfortunately provided “too many” tablets of oxycodone.

Case 1 (continued)

- Her husband is present during appointment and corroborates the patient's story.
- You conduct a chart review and see that the patient presented to an ER 2 years ago under similar circumstances. Her work-up was unremarkable. After returning to baseline in the ER (Narcan was not provided), the patient was discharged home and was advised to follow-up with her PCP.
- Current medications include: Oxycodone, baclofen, Effexor, Wellbutrin, trazodone, Abilify and lisinopril.

Case 1 (continued)

- WHAT NEXT?
- DOES SHE HAVE ADDICTION?
- Interview patient and husband separately.
- Express concern, not disappointment or discontent.
  - Example: “I’m worried about you and I’m concerned that something else may be going on.”
- Make statement which make admission of addictive behaviors less intimidating.
  - “Oxycodone is a very powerful medication, and it’s not uncommon for this drug to make people do things they don’t want to do, including taking more than they should.”

Case 1 (continued)

- Likely outcomes:
  - Patient and husband will not admit to any inappropriate use, even when interviewed separately.
  - Patient will likely not admit to addictive behaviors because she knows the med will be discontinued and/or she will be labeled as an “addict.”
  - Patient and/or husband will present solutions to you on why/how this will never happen again.
    - “Doctor, we will start doing …… and I promise to see you every week.”

Case 1 (continued)

- Possible clinical outcomes and interventions:
  - Conclude patient has OUD without her admission, d/c oxycodone and start buprenorphine.
    - NOTE: Patient still MUST consent to buprenorphine therapy, and you need to fully disclose your reasons for using the medication.
  - Discontinue oxycodone and discharge patient from practice (not recommended).
  - Discontinue oxycodone and continue to work with patient.
  - Continue oxycodone with the following conditions: only 1-2-week supplies provided, frequent UDS, pill counts.
  - Do nothing (not recommended)

Case 1 (continued)

SOME TAKE HOME POINTS:

- Collateral sources of information, such a spouse, may not be helpful.
- You may never find out what's going on with a patient, no matter what you do or how good you are.
- Treatment is a process that is not completed in 1 or 2 sessions.
  - Progress is measured in months and years, not days.
- Patient may NOT admit to you that they have an addiction but will accept treatment (rare occurrence, but it does happen).
- The best thing you can do with a non-committal patient is ESTABLISH TRUST.

How to diagnose an opioid use disorder?

Addiction Definition

- A primary, chronic disease of brain reward, motivation, memory and related circuitry.
- Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations.
- This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.
- Addiction is characterized by
  - inability to consistently abstain from drug use.
  - impairment in behavioral control.
  - craving.
  - diminished recognition of significant problems with one's behaviors and interpersonal relationships.
  - a dysfunctional emotional response.
- Like other chronic diseases, addiction often involves cycles of relapse and remission.
- Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

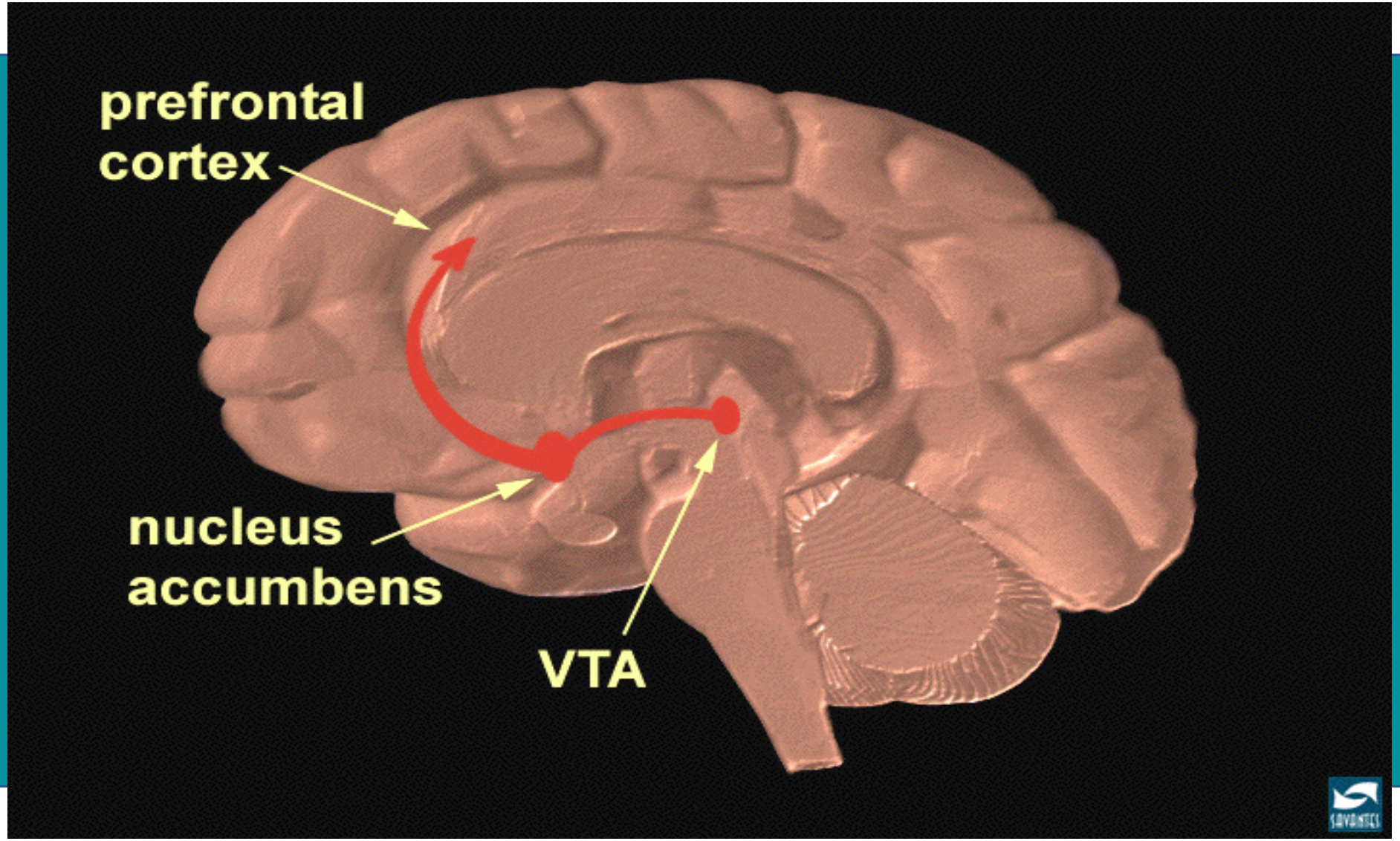
4 C's

Loss of **C**ontrol

Compulsive use

Use despite **C**onsequences

Cravings



What's Happening in the Brain?

Some Clinical Points

Addiction is Much More than Compulsive Drug Use

- Addiction is a BEHAVIORAL SYNDROME, which involves personality changes, functional decline, and lapses in judgement, insight, and decision making.

- Addiction can be VERY DIFFICULT to diagnose.
  - Patients can be very well versed in concealing the problem from healthcare providers.

Definitions

- DSM IV terminology
  - Addiction = Dependence
  - Do not confuse this definition of “dependence” with “physical dependence”
- DSM-V terminology
  - Addiction = Substance Use Disorder
- NOTE: The word “addiction” is not used in the DSM diagnostic terminology.
  - DSM IV: Dependence
  - DSM V: Substance use disorder

Physical Dependence

- An altered state of physiology resulting from prolonged drug exposure, resulting in tolerance and/or withdrawal.
  - Example: a patient experiences opiate withdrawal after stopping morphine 72 hours ago.
- It is a normal physiological response, and is NOT indicative of addiction, by itself.
- Is NOT necessary to make a diagnosis of addiction (substance use disorder).

Substance Use Disorder

- Criteria are universal for ALL substances. (ex. Nicotine Use Disorder has the same diagnostic criteria as Cocaine Use Disorder).
    - The behavioral phenotypes of addiction are very similar, regardless of class of drug is being used.
    - Example: Behaviors associated with opiate addiction mirror those of cocaine addiction.

Substance Use Disorder

DSM 5 Diagnostic Criteria

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by 2 (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
2. Recurrent substance use in situations in which it is physically hazardous.
3. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

Substance Use Disorder

DSM 5 Diagnostic Criteria (continued)

4. Tolerance (excluded if the drug is prescribed under medical supervision).
5. Withdrawal (excluded if the drug is prescribed under medical supervision).
6. The substance is often taken in larger amounts or over a longer period than was intended.
7. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
8. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.

Substance Use Disorder

DSM 5 Diagnostic Criteria (continued)

9. Important social, occupational, or recreational activities are given up or reduced because of substance use.
10. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
11. Craving or a strong desire or urge to use a specific substance.

Substance Use Disorder

Severity Specifiers

- Mild: 2-3 positive criteria
- Moderate: 4-5 positive criteria
- Severe: 6 or more positive criteria
- Specify if:
  - With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either Item 4 or 5 is present).
  - Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither Item 4 nor 5 are present)

What Drugs Can Cause Addiction?

- Only certain drugs are addictive and able to stimulate the addiction circuitry.
  - Opiates/opioids
  - Cannabinoids (marijuana)
  - Psycho-stimulants (Adderall, cocaine)
  - Sedative/hypnotics (Benzodiazepines)
  - Nicotine
  - Alcohol
- Relatively very few chemical compounds can stimulate the addiction circuitry, in comparison to all the drugs known.

Key Points in Diagnosing Addiction

- **Recurrence is the key**
- Recurring adverse consequences.
- Look for loss or turmoil in the following:
  - Home life
  - Work performance
  - Relationship with spouse, significant other, friends and/or family
  - Finances
  - Psychological functioning

Diagnosing Addiction in the Challenging Patient

- Clinical Pearls:
  - Do not ask direct questions about drug use, given that the patient will misrepresent themselves.
  - Obtain a detailed social and demographic history.
    - Current residence: “Where are you currently staying?”
    - Employment
    - Relationship status with family and/or spouse/S.O.
    - Pending legal issues
    - Financial hardships
  - Try and create a TRUSTING and non-judgmental environment to the best of your ability.

Diagnosing Addiction:
The Interview

- Clinical Pearls:
  - Consider starting with DEMOGRAPHICS and social history:
  - Example narrative: “Given that this is your first time in our clinic, I’d to take some time to get to know you so I have a sense of what might be going on. With all my new patients, I typically get a sense of their current living and social environment and that’s where I’d like to start.”
  - Make sure you express **interest** (this is very important and will allow the patient to open up to you).

Patient Assessment

Patient Assessment

Good clinical care should include these interviewing styles.

- Open-ended questions
- Empathetic demeanor
- Working with the patient collaboratively (ex. “Let’s work on this together.”)
- Establishing trust and allowing the patient to feel that he/she can be honest during sessions.
  - The patient will know that they will not be shamed if they use or if they experience a relapse.

Patient Assessment

Interviewing styles which are NOT helpful.

- The use of pejorative terms:
  - Abuse, addict, alcoholic.
- Shaming or guilting the patient:
  - “Do you have any idea what you’re doing to yourself and to your family?”
- Authoritative style:
  - “If you smoke marijuana one more time, you’ll be discharged from my care.”

Diagnosing Addiction:
The Interview

- Some good questions for the social history:
  - How are things going at home?
  - What is your (spouse/S.O) like?
  - You mentioned you work at X, how are things going there?
  - Do you worry about money often? Why is that?
  - Are you dealing with any current legal problems? Have you had run-ins with the police in the past? Would you feel comfortable telling me about it?

SIDE NOTE: asking permission to inquire on a question is a great clinical move. It shows respect and acknowledges that this may be a sensitive area.

Patient Interpretation of the Problem

- They will minimize or deny the problem.
  - This is a SYMPTOM of the disease and is common during patient presentations.
  - Patients will “protect” their relationship with the drug and may block interventions that interfere with their drug use.
  - Addiction causes patients to undergo a **personality metamorphosis**.
  - Patients may begin to manipulate, lie, and steal, in order to satiate their drug craving.

Patient Assessment:

What to look for

- Social cues:
  - Lying
  - Stealing
  - Manipulative behaviors
  - Various complaints from family members
  - Relationship turmoil
  - Personality changes (short tempered, agitated, mood swings)
  - Family reports large amounts of money missing.
  - Decreased work performance or job termination.

Discussing Addiction with the Challenging Patient

"I think you have **vulnerability** to opioids, and this is causing your body to crave these drugs and make you do things that are against your better judgment. What do you think?"

"I understand you disagree with my assessment and you're welcome to get an opinion from another provider. I'm going to give you my card, and I want you to come back and see me if you change your mind."

Action Period Assignment

- Think of 3 social history questions NOT directly related to substance use which may help you diagnose SUD in a patient.
- Based on what you learned today, what office practices can you implement that might help you in diagnosing a substance use disorder in a patient?

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Thank You

Please email me at ejouney@med.umich.edu with any questions.