

# MACS

**Maryland Addiction Consultation Service**

**1-855-337-MACS**

**[www.marylandMACS.org](http://www.marylandMACS.org)**



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# Maryland Addiction Consultation Service (MACS)

*Provides support to primary care and specialty prescribers across Maryland in the identification and treatment of Substance Use Disorders and chronic pain management.*

## **All Services are FREE**

- ▶ Phone consultation for clinical questions, resources, and referral information
- ▶ Education and training opportunities related to substance use disorders and chronic pain management
- ▶ Assist in the identification of addiction and behavioral health resources that meet the needs of the patients in your community
- ▶ Administered by UMB School of Medicine and funded by Maryland Department of Health, Behavioral Health Administration

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# Treating opioid use disorder in a primary care setting

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AAHIVS

# Disclosures

- ▶ **None, except strong passion for integrating addiction treatment with primary care**

# Objectives

- ▶ **To increase knowledge of epidemic of opioid use disorder**
  - ▶ **To increase knowledge of treatment of opioid use disorder**
  - ▶ **To be convinced that integrating treatment for substance (opioid) use disorder with primary care is beneficial (for patient, providers and the health system)**
- 

# Patient vignette 1

- ▶ EB is a 72 F seen for initial visit. She has a history of chronic pain in hips and knees. Her previous provider will no longer prescribe oxycodone as for the past 2 months her 30 day script ran out after 2 weeks. Tearful and fearful that providers won't help her. Cannot take NSAIDs. She admits that she often takes oxycodone when she is upset.
- ▶ She lives alone in senior housing apartment; 2 daughters– both with difficulties (medical and social). Non-smoker; no alcohol.

# Patient vignette 1 outcome

- ▶ After spending time building rapport and making sure she knew my goal was to work with her, I explained I would not prescribe her oxycodone.
- ▶ She was open to undoing isolation, treating mood and trying buprenorphine.
- ▶ Almost immediately, physically more active (no longer dwelling on when next dose of pain medication is and does she have enough), remains on low dose buprenorphine, never running out before she should, with improved pain.

# Patient vignette 2

- ▶ **KL is a 65F retired nurse who had right total knee replacement complicated by joint infection requiring prolonged course of antibiotics, hardware removal with spacer and finally replacement of hardware. She has been on oxycodone 15 mg four times daily for 4 months.**
- ▶ **She sees orthopedics in f/u and is told she should not be on any further opioids as she is now 2 weeks out since the last surgery. She is told to take ibuprofen.**

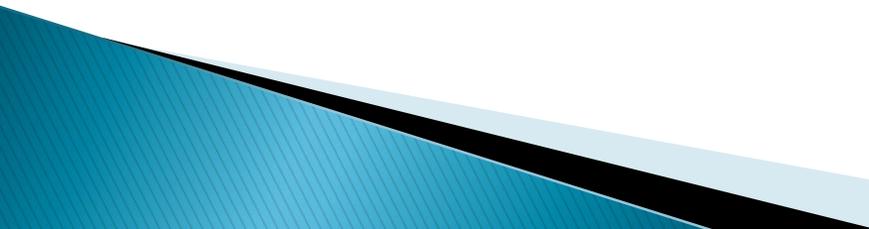
# Patient vignette 2 outcome

- ▶ I receive a call from the police that KL had died from an apparent opioid overdose
  - ▶ I find out from her son that she had gone into severe opioid withdrawal and bought opioids on the street.
- 

# Patient vignette 3

- ▶ **28F seen for first visit. Able to review in CRISP/PDMP– multiple ER visits for back pain and one opioid overdose, and many filled scripts for oxycodone from many providers. Had abnormal PAP 3 years ago. History of HIV (not addressed) and hypertension (has elevated BP today)**
- ▶ **Her agenda– getting script for oxycodone. My agenda– getting her engaged in medical care and treatment for opioid use disorder**

# Patient vignette 3 outcome

- ▶ **After 3 months - seen her 7 times**
  - ▶ **Doing well on buprenorphine/naloxone. No back pain. Urine drug screens all negative since the first visit.**
  - ▶ **On medication for hypertension; adherent with HAART for HIV; had PAP done. No ER visits.**
  - ▶ **Mood/self-esteem much improved. Better relationship with family. Working part-time.**
- 

# Brooklyn 1974



# Bronx 1984



# The admission board...

**“SWAF”**

# STIGMA and PREJUDICE





# Despair



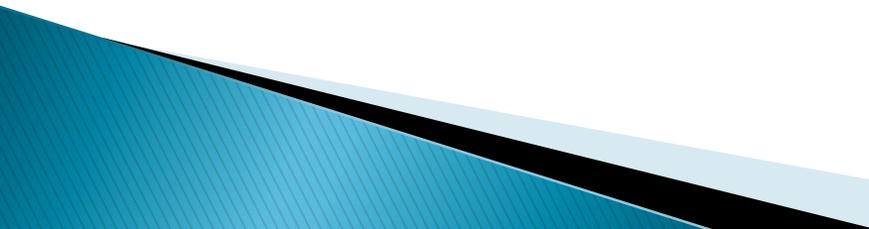
# Integration of substance use disorder treatment and primary care

- ▶ In 2006, the IOM released a report recommending improvement in coordination of mental health and substance-related services into general health care services:
  - ▶ “Available evidence suggests that integration of mental health and primary care may lead to improved care and quality of life”
  - ▶ “Studies of health delivery, process of care, and health outcomes in integrated clinical settings will be critical to inform the process”
- 

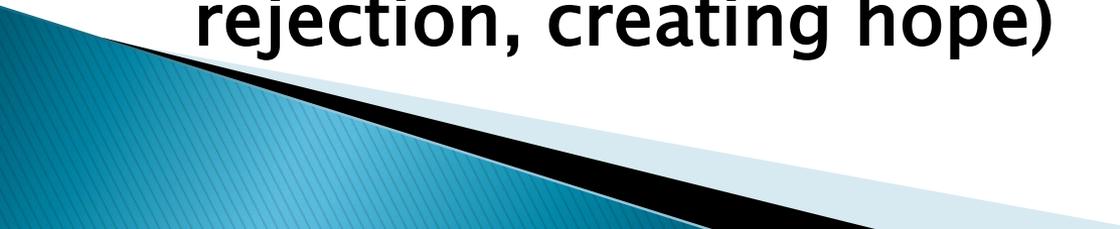
# What should providers expect from their patients with addiction?

- ▶ **Desire to receive care that will improve health**
- ▶ **Engagement in care based on trust and rapport**

**Press K, Zornberg G, Geller G, Carrese J, Fingerhood M. What patients with addiction disorders need from their primary care physicians: a qualitative study. Substance Abuse 2016; 37:349–55.**



# What do patients with addiction need from their providers

- ▶ **Knowledge about addiction**
  - ▶ **Duty to treat**
  - ▶ **Focus on overall health**
  - ▶ **Engage patients in care**
  - ▶ **Treat the full scope of illness (isolation, rejection, creating hope)**
- 

# Health burden of SUD and opioid use disorders

- ▶ In 2016, an estimated 25 million persons aged 12 or older (9.4 percent) were current illicit drug users
    - Despite the high prevalence, the vast majority of individuals who need treatment do not receive it
    - The economic burden of substance use in the US is estimated at \$524 billion/year much of which is attributed to losses in productivity
  - ▶ In 2016, over 4.5 million Americans aged 12 and older met the criteria for substance use disorder related to opiate analgesics, and over 700,000 used heroin in the past year
  - ▶ According to the CDC, drug overdose death rates in the US have more than tripled since 1990 and are at an all-time high, surpassing motor vehicle accident deaths
- 



# Opiates & Opioids



The sap is extracted  
by slitting the pod

Highly refined Southwest Asian heroin or  
Southeast Asian heroin



***Opiates*** = naturally present in opium

- e.g. morphine, codeine, thebaine

***Opioids*** = manufactured

- Semisynthetics are derived from an opiate
  - Heroin from morphine
  - Buprenorphine, oxycodone from thebaine
- Synthetics are completely man-made to work like opiates
  - Methadone
  - Fentanyl

# Narcotic Regulation in US

- ▶ **1914- Harrison Narcotics Tax Act**
  - ▶ **1925- Linder vs United States**
  - ▶ **1964- Methadone introduced as experimental treatment for opioid addiction**
  - ▶ **1968- Bureau of Narcotic and Dangerous Drugs formed (changed to DEA in 1973)**
- 

# DSM5– Opioid Use Disorder

- ▶ **Group 1 – Impaired control**– larger amounts and longer; desire to cut down; great deal of time spent related to using; craving
  - ▶ **Group 2–Social impairment**– failure to fulfill obligations; interpersonal problems; reduction in social, occupational or recreational activities
- 

# DSM5– Opioid Use Disorder

- ▶ Group 3– **Risky use**– use in hazardous situations; continued use despite negative consequences
  - ▶ Group 4– **Pharmacologic dependence**– tolerance; withdrawal with cessation
- 

# Identifying

- ▶ **Ask**
  - ▶ **Survey/screening tools**
  - ▶ **Clinical assessment**
  - ▶ **Local medical record**
  - ▶ **CRISP/PDMP**
  - ▶ **Search criminal record?**
- 

# Where does SBIRT work best?

- A. Primary care**
  - B. Emergency room**
  - C. Inpatient hospital**
  - D. All places equally**
- 

**But here is my bias (and reason for  
webinar):**

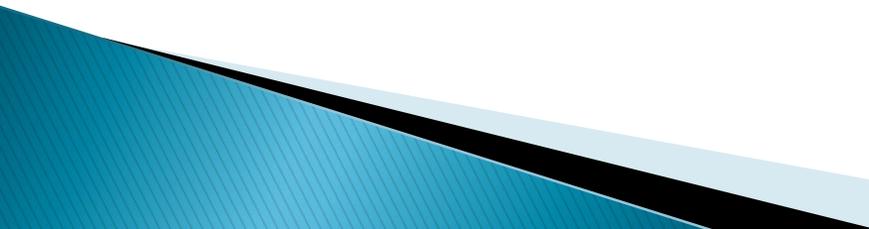
**SBIRT**

**VS**

**SIT (screen, intervene and treat)**



# Intervention– “I have joined your fan club”

- ▶ **Interventions and education are effective**
  - ▶ **Interventions should emphasize health and relationship benefits**
  - ▶ **Use family/friends in a positive way**
  - ▶ **Avoid threats- “If you use, you will die”**
  - ▶ **Give hope that life can improve**
  - ▶ **Acknowledge reasons for use, but...**
  - ▶ **Work together to define the benefits of change**
- 

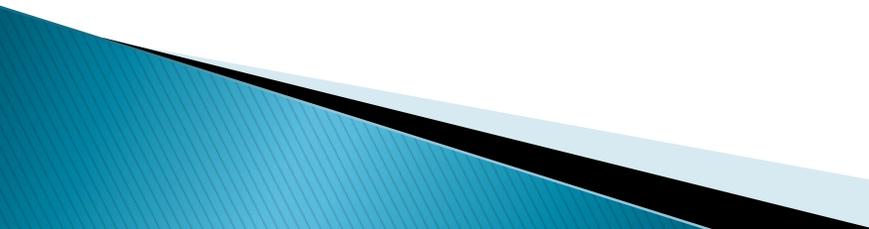
# **Traditional Approach**

- 1. Accepting powerlessness**
  - 2. Disease identification**
  - 3. Surrender to a Higher Power**
  - 4. Commitment to AA/NA**
  - 5. Commitment to abstinence**
  - 6. Sober social support**
  - 7. Intention to avoid high-risk situations**
- 

# Rationale for Opioid Replacement Therapy

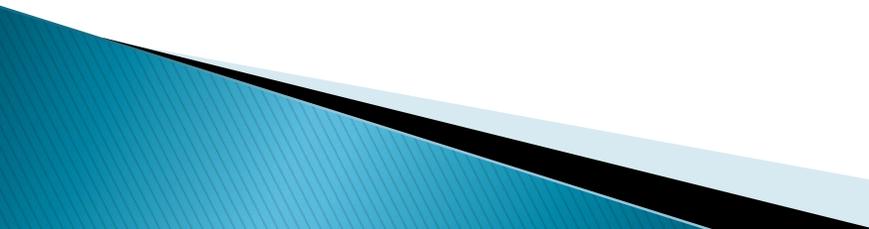
- ▶ **Stabilize neuronal circuitry**
    - **Mu occupation/blockade**
    - **Cross-tolerant, long-acting**
  - ▶ **Prevent withdrawal and craving**
  - ▶ **Extinguish compulsive behavior**
  - ▶ **Prevent spread of HIV and HCV**
  - ▶ **Prevent criminal activity**
- 

# What about naltrexone for opioid use disorder?

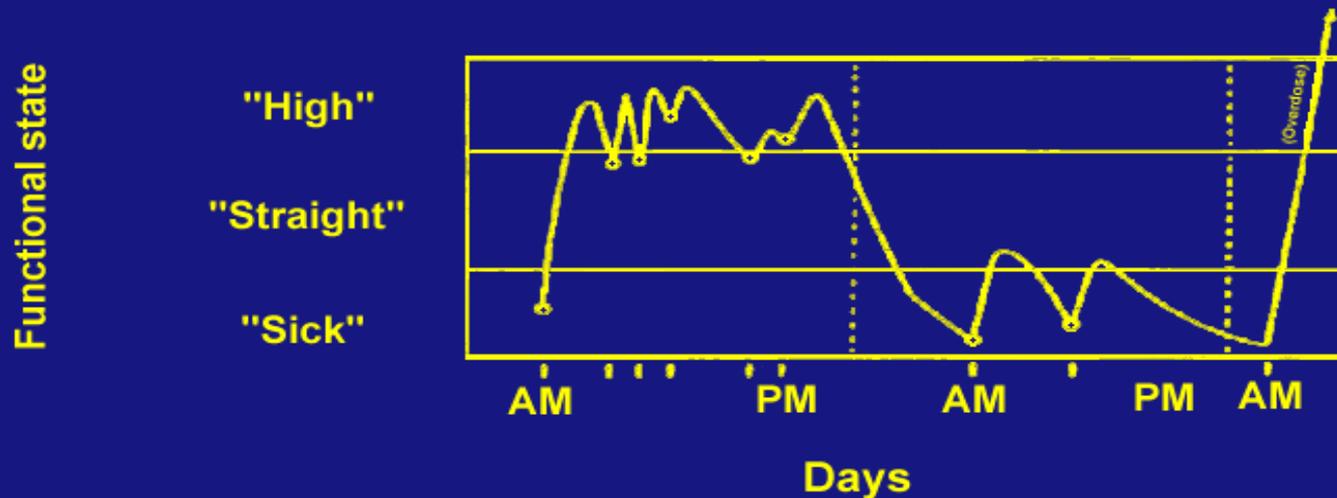
- ▶ **Pure opioid blocker**
  - ▶ **Available as oral drug and monthly injection**
  - ▶ **Acceptance poor**
  - ▶ **Works if part of contingency management**
  - ▶ **Little evidence for long term efficacy**
- 

# Effective Treatment of Opiate Addiction

NIH Consensus Development Conference  
November 17–19, 1997

- **Opiate dependence is a brain-related medical disorder**
  - **Treatment is effective-**
    - **“Although a drug-free state represents an optimal treatment goal, research has demonstrated that this goal cannot be achieved or sustained by the majority of opiate-dependent people.”**
  - **Reduce unnecessary regulation of long-acting agonist treatment programs**
  - **Improve training of health care professionals in treatment of opiate dependence**
- 

# What the opioid dependent patient feels...



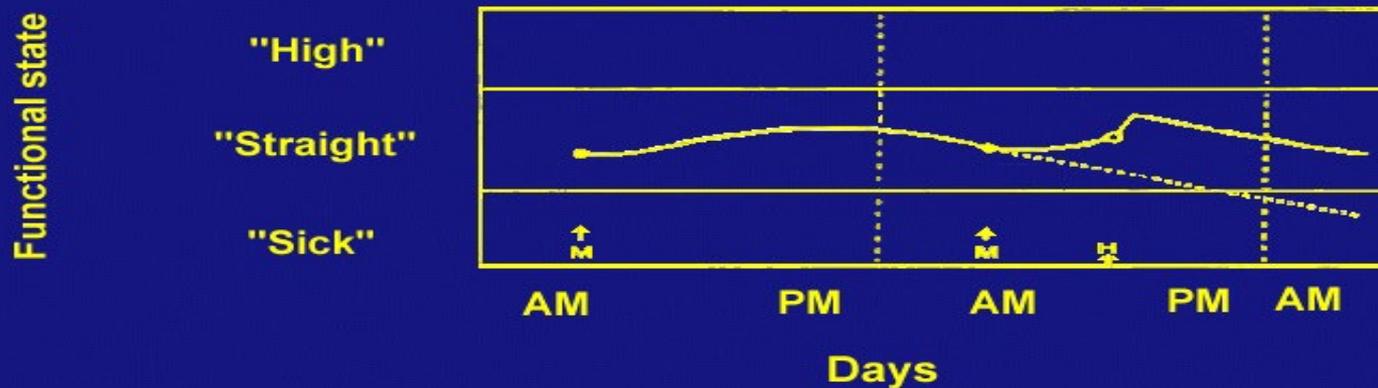
Diagrammatic summary of functional state of typical "mailine" heroin user. Arrows show the repetitive injection of heroin in uncertain dose, usually 10 to 30 mg but sometimes much more. Note that addict is hardly ever in a state of normal function ("straight").

From "Narcotic Blockade," by V. P. Dole, M. E. Nyswander, and M. J. Kreek, 1966, Archives of Internal Medicine, 118, p. 305.

**MEDICATIONS**

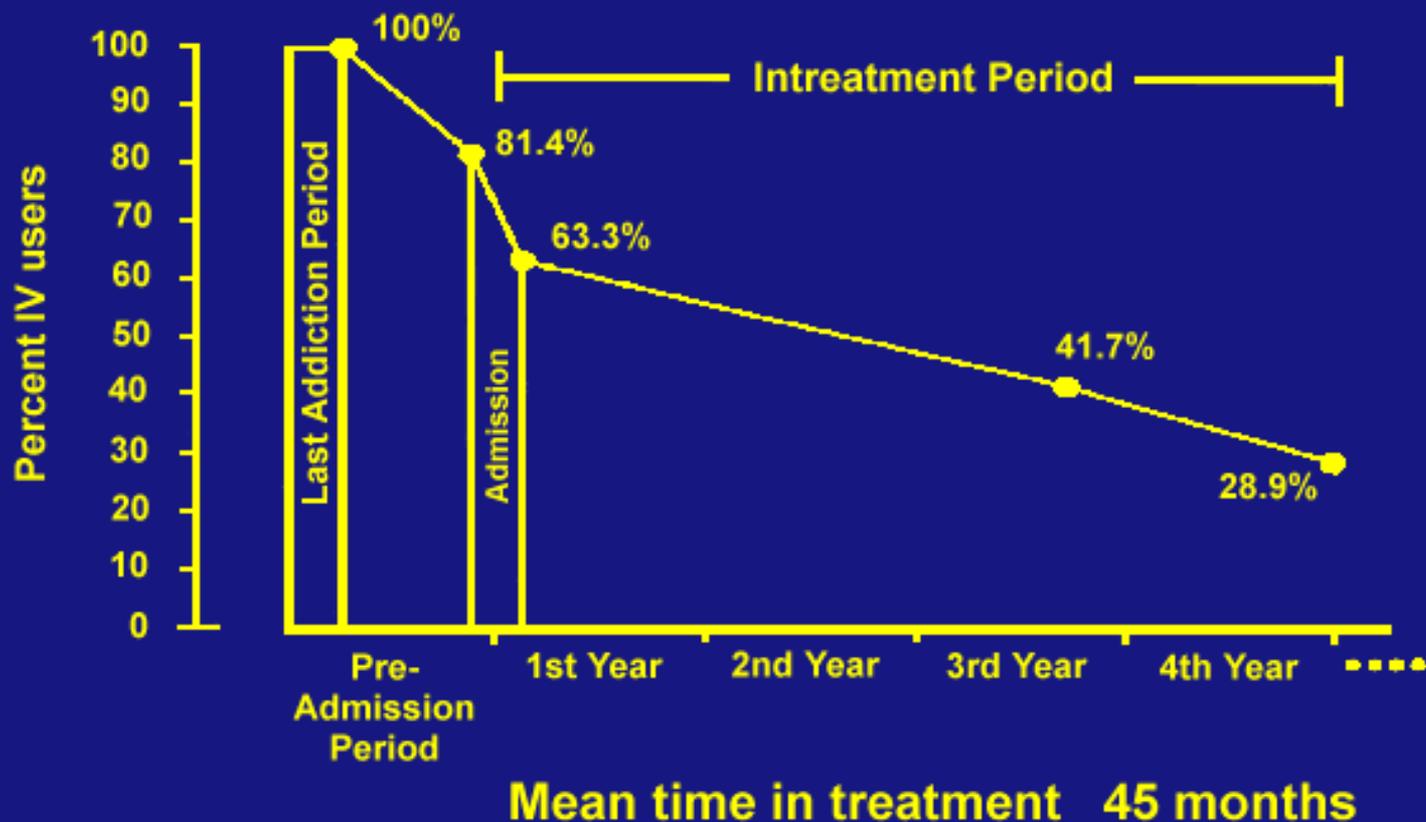
**NOT MAT**

# Stabilization by Blockade Treatment



**Stabilization of patient in state of normal function by blockade treatment. A single daily oral dose of methadone prevents him from feeling symptoms of abstinence ("sick") or euphoria ("high"), even if he takes a shot of heroin. Dotted line indicates course if methadone is omitted.**

From "Narcotic Blockade," by V. P. Dole, M. E. Nyswander, and M. J. Kreek, 1966, *Archives of Internal Medicine*, 118, p. 305.



**Impact of methadone maintenance treatment on intravenous drug use for 388 male methadone patients in six programs.**

From the Effectiveness of Methadone Maintenance Treatment (p. 169), by J. C. Ball and A. Ross, 1991, New York: Springer-Verlag. Copyright by Springer-Verlag New York, Inc. Reprinted with permission.

# **Drug Abuse Treatment Act (DATA) of 2000**

- ▶ **Allowed “Qualified” physicians to treat opioid dependence outside methadone facilities**
  - 1. Addiction certification from approved organization, or**
  - 2. Physician in clinical trial of qualifying medication, or**
  - 3. Complete 8-hour course from approved organization**
- ▶ **DEA issues (free) to qualifying physicians a new DEA number to use medication for opioid dependence**
- ▶ **As of today, only one medication formulation is approved for this use**

# Opioid Treatment: Changing Approach

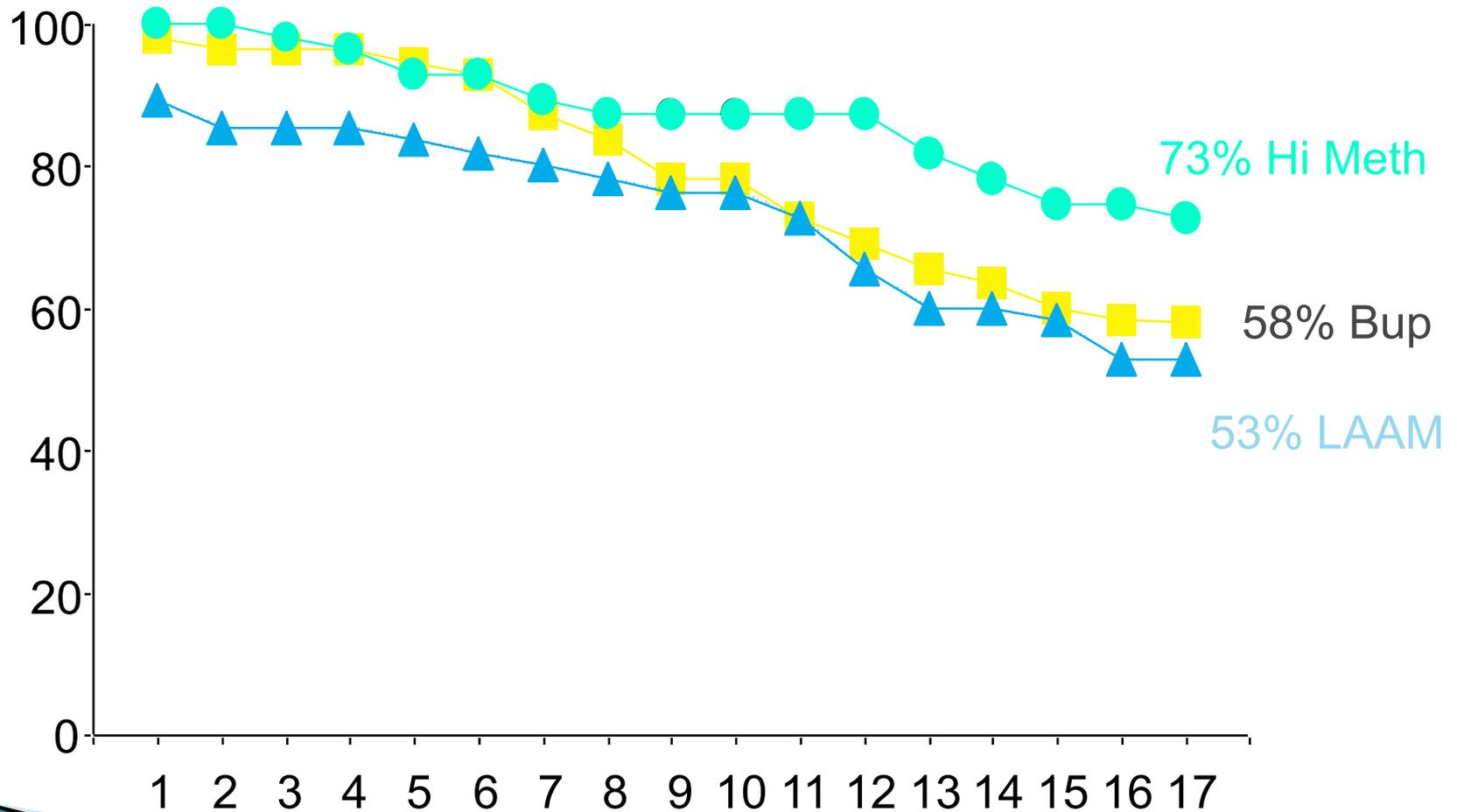
## Methadone Clinic

- **Criteria:**
  - Withdrawal**
  - 12 months use**
- **Dose regulated**
- **Age > 18**
- **Limited take homes**
- **Services “required”**

## Buprenorphine

- **Criteria:**
  - DSM IV**
  - No time criteria**
- **MD sets dose**
- **Age > 16**
- **Take homes (30 days)**
- **Services must be “available”**

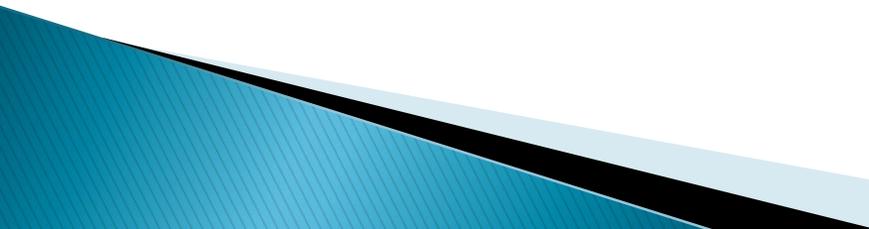
# Buprenorphine, Methadone, LAAM: Treatment Retention



Johnson RE, et al NEJM 2000

# Buprenorphine's Properties

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- ▶ **Modest  $\mu$  agonist activity with ceiling**
  - ▶ **Long half life**
  - ▶ **Precipitated withdrawal if taken after full agonist**
  - ▶ **Sublingual route of administration**
  - ▶ **“Combo” tablet with naloxone limits abuse by injection**
- 

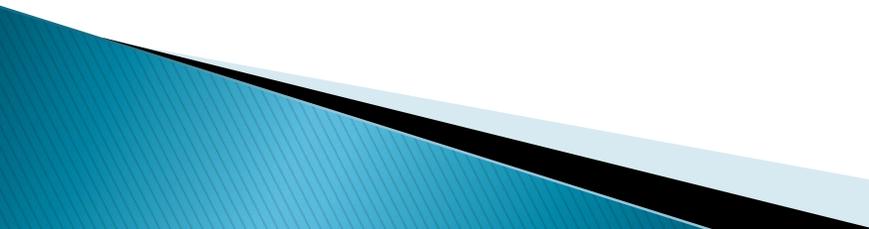
# Buprenorphine Safety

- ▶ **No alteration of cognitive functioning**
  - feel “normal”
- ▶ **No organ damage**
  - Early concern of hepatic toxicity unconfirmed
  - No evidence of QT prolongation
- ▶ **Ceiling prevents respiratory depression, OD**  
(Overdose reports with combining use with benzodiazepines)
- ▶ **No clinically significant interactions with other drugs**

# Stop using this term:



# Starting buprenorphine

- ▶ Done at home
  - ▶ No different than starting blood pressure medication– may need some titration
  - ▶ Much easier than starting insulin (and safer)
  - ▶ Counsel on taking first dose once in withdrawal
  - ▶ Titrate dose up to 16 mg/daily by second day
  - ▶ Phone check ins
  - ▶ One week follow-up
- 

**But don't I need to  
provider a counselor?**

Adjunctive Counseling During Brief and Extended  
Buprenorphine–Naloxone Treatment for Prescription Opioid  
Dependence: *A 2-Phase Randomized Controlled Trial*  
*Roger D. Weiss, MD; Jennifer Sharpe Potter, PhD; David A. Fiellin,  
MD et. al. Arch Gen Psych 2011; 68:1238–1246*

- ▶ **Multicenter randomized clinical trial- n=653**  
**In both phases patients randomized to standard  
medical management(SMM) or SMM plus  
counseling**  
**In both phases (3 &12 weeks of buprenorphine),  
separate counseling did not change outcomes**

# Combined Pharmacotherapies and Behavioral Interventions for Alcohol Dependence

## The COMBINE Study: A Randomized Controlled Trial

Raymond F. Anton, MD  
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Ron A. Geler, PhD  
David Couper, PhD  
Dennis M. Donovan, PhD  
David R. Gustfriend, MD  
James D. Hasking, PhD  
Barkok A. Johnson, MD, PhD  
Joseph S. LeCoster, PhD  
Richard Longabaugh, EdD  
Barbara J. Mason, PhD  
Margaret E. Mattson, PhD  
William R. Miller, PhD  
Helen M. Petimová, PhD  
Carris L. Randall, PhD  
Robert Swift, MD  
Roger D. Weiss, MD  
Lauren D. Williams, MD  
Allen Zeeben, DSW  
for the COMBINE Study Research Group

**A**BOUT 8 MILLION INDIVIDUALS IN the United States currently meet diagnostic criteria for alcohol dependence, a leading preventable cause of morbidity and mortality and a major contributor to health care costs.<sup>1,2</sup> In primary care settings, the prevalence of alcohol use disorders ranges from 20% to 36%;<sup>3</sup> most of these patients are never treated and, if they are

**Context:** Alcohol dependence treatment may include medications, behavioral therapies, or both. It is unknown how combining these treatments may impact their effectiveness, especially in the context of primary care and other nonspecialty settings.

**Objectives:** To evaluate the efficacy of medication, behavioral therapies, and their combinations for treatment of alcohol dependence and to evaluate placebo effect on overall outcome.

**Design, Setting, and Participants:** Randomized controlled trial conducted January 2001-January 2004 among 1383 recently alcohol-abstinent volunteers (median age, 44 years) from 11 US academic sites with *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* diagnosis of primary alcohol dependence.

**Interventions:** Eight groups of patients received medical management with 15 weeks of naltrexone (100 mg/d) or acamprosate (3 g/d), both, and/or both placebos, with or without a combined behavioral intervention (CBI). A ninth group received CBI only (no pills). Patients were also evaluated for up to 1 year after treatment.

**Main Outcome Measures:** Percent days abstinent from alcohol and time to first heavy drinking day.

**Results:** All groups showed substantial reduction in drinking. During treatment, patients receiving naltrexone plus medical management ( $n=302$ ), CBI plus medical management and placebo ( $n=305$ ), or both naltrexone and CBI plus medical management ( $n=308$ ) had higher percent days abstinent (80.6, 79.2, and 77.1, respectively) than the 79.1 in those receiving placebo and medical management only ( $n=305$ ), a significant naltrexone  $\times$  behavioral intervention interaction ( $P=.008$ ). Naltrexone also reduced risk of a heavy drinking day (hazard ratio, 0.72; 95% CI, 0.63-0.98;  $P=.02$ ) over time, most evident in those receiving medical management but not CBI. Acamprosate showed no significant effect on drinking vs placebo, either by itself or with any combination of naltrexone, CBI, or both. During treatment, those receiving CBI without pills or medical management ( $n=157$ ) had lower percent days abstinent (66.6) than those receiving placebo plus medical management alone ( $n=153$ ) or placebo plus medical management and CBI ( $n=156$ ) (73.8 and 79.8, respectively;  $P<.001$ ). One year after treatment, these between-group effects were similar but no longer significant.

**Conclusions:** Patients receiving medical management with naltrexone, CBI, or both fared better on drinking outcomes, whereas acamprosate showed no evidence of efficacy, with or without CBI. No combination produced better efficacy than naltrexone or CBI alone in the presence of medical management. Placebo pills and meeting with a health care professional had a positive effect above that of CBI during treatment. Naltrexone with medical management could be delivered in health care settings, thus serving alcohol-dependent patients who might otherwise not receive treatment.

**Trial Registration:** clinicaltrials.gov Identifier: NCT00006206

JAMA. 2005;293:2003-2017

www.jama.com

**Author Affiliations:** are listed at the end of this article.  
**Members of the COMBINE Study Research Group** are listed at the end of this article.

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# Support groups?

**“You’re not in recovery if you’re  
on medication”**

# Quotes from patients on buprenorphine

**“Doc, I feel normal”**

**“I wake up not sick”**

**“I have my life back”**

- ▶ **Treatment in normal medical settings:**
  - **Encourages continuity of medical care**
  - **Encourages relationship building**
  - **Legitimizes opioid use disorder as a treatable, chronic illness**

# Opioid Dependence Treatment in Primary Care

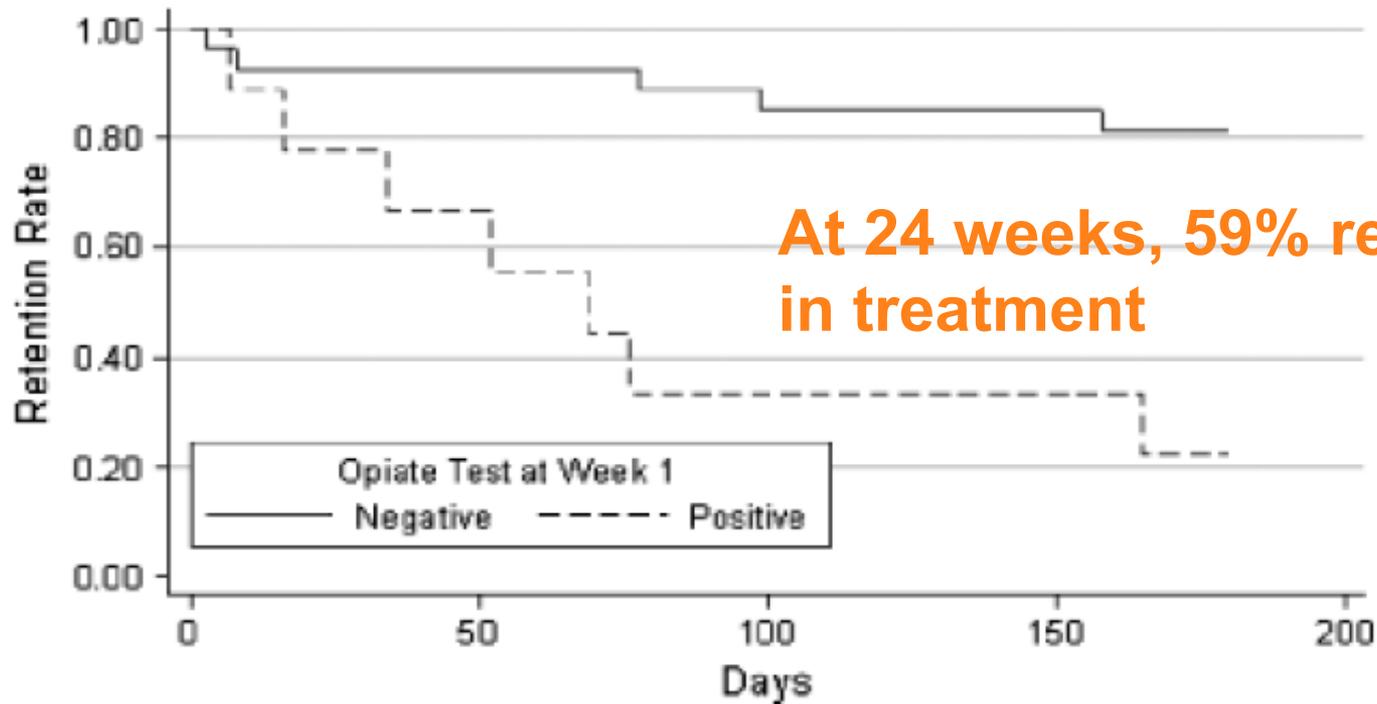


FIGURE 1. Program retention time by week 1 opiate test.

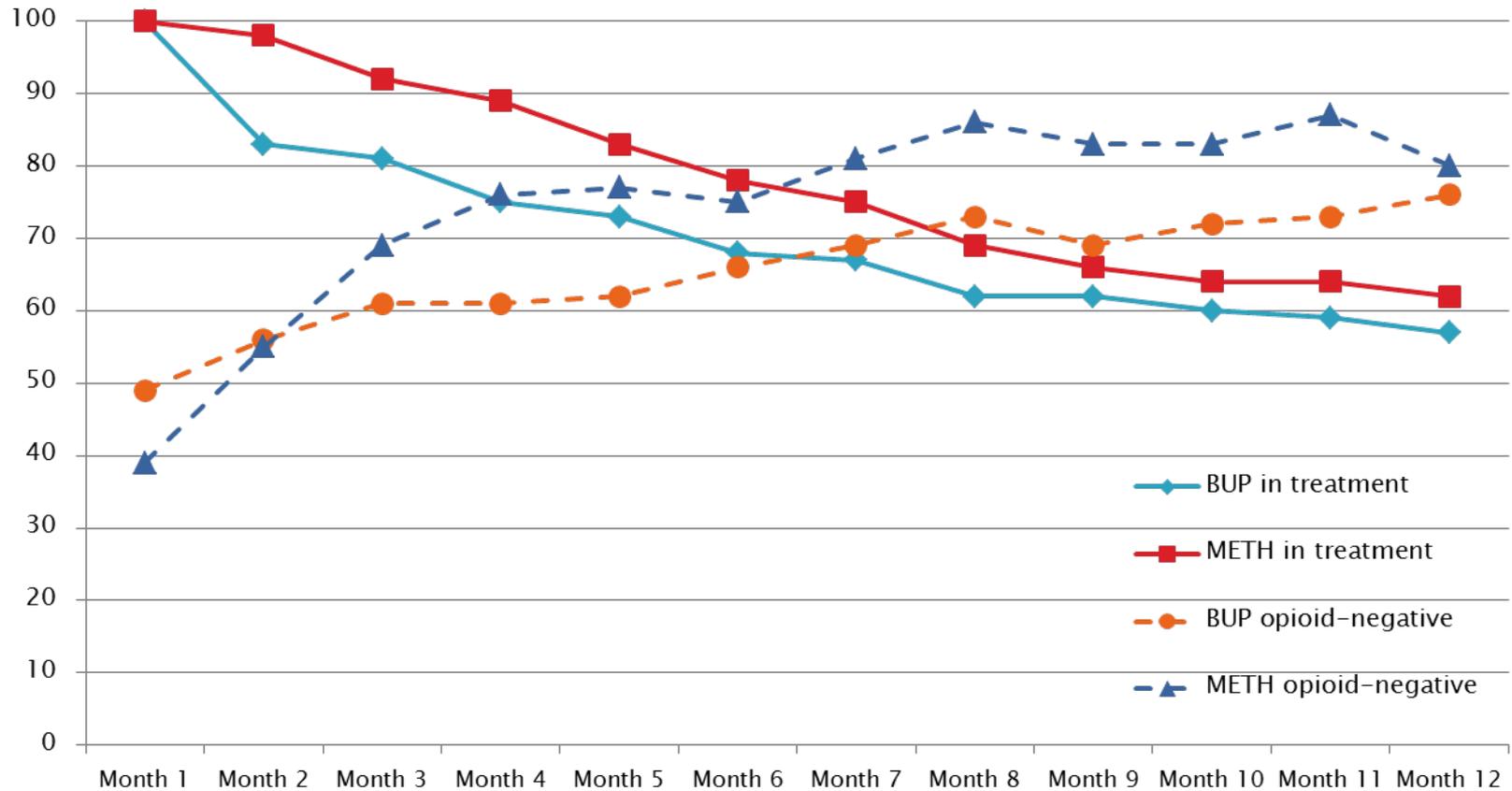
# Characteristics –252 in each arm

Characteristic	BUP	METH	P value
Mean Age	39.7	39.5	0.83
Female	44%	58%	0.001
Insurance			
Commercial	41%	1%	<0.001
Medicare	20%	3%	<0.001
Medicaid	35%	56%	<0.001
None	3%	39%	<0.001
Employment			
Employed	45%	13%	<0.001
Unemployed	29%	72%	<0.001
Disabled	26%	16%	<0.001

# Characteristics

Characteristic	BUP	METH	P value
Abused Substances			
Heroin	83%	86%	0.39
Opioid Rx	29%	9%	<0.001
Cocaine	53%	55%	0.73
Benzodiazepines	9%	23%	<0.001
Injection drug use	61%	69%	0.051
HIV infection	14%	8%	0.023
Chronic pain	18%	12%	0.063
Recent criminal charges	43%	50%	0.129

**Figure 1: Percentage of patients in treatment at each month and percentage of those in treatment who were opioid-negative. (BUP – buprenorphine, METH – methadone).**



# Integrated buprenorphine cost study

- ▶ **Maryland Medicaid Priority Partners beneficiaries who received a script for buprenorphine between 1 / 1 / 08 and 7 / 31 / 12 and no buprenorphine script in previous 3 months**
  - ▶ **Only first episodes analyzed**
- 

# Buprenorphine cost study

	CCP n=137	Non-CCP n=992	
6 month retention	80.3%	59.2%	p<.001
Any ED visit 12 months	63.5%	60.4%	NS
Any acute hospital stay 12 months	15.3%	18.9%	NS
Total cost 12 months mean	\$10,785	\$12,210	P<.001

So now I am convinced (maybe) I should prescribe in my primary care setting...

- ▶ Prescribing is the easy part
- ▶ The conversation is the art of medicine (and the fun)

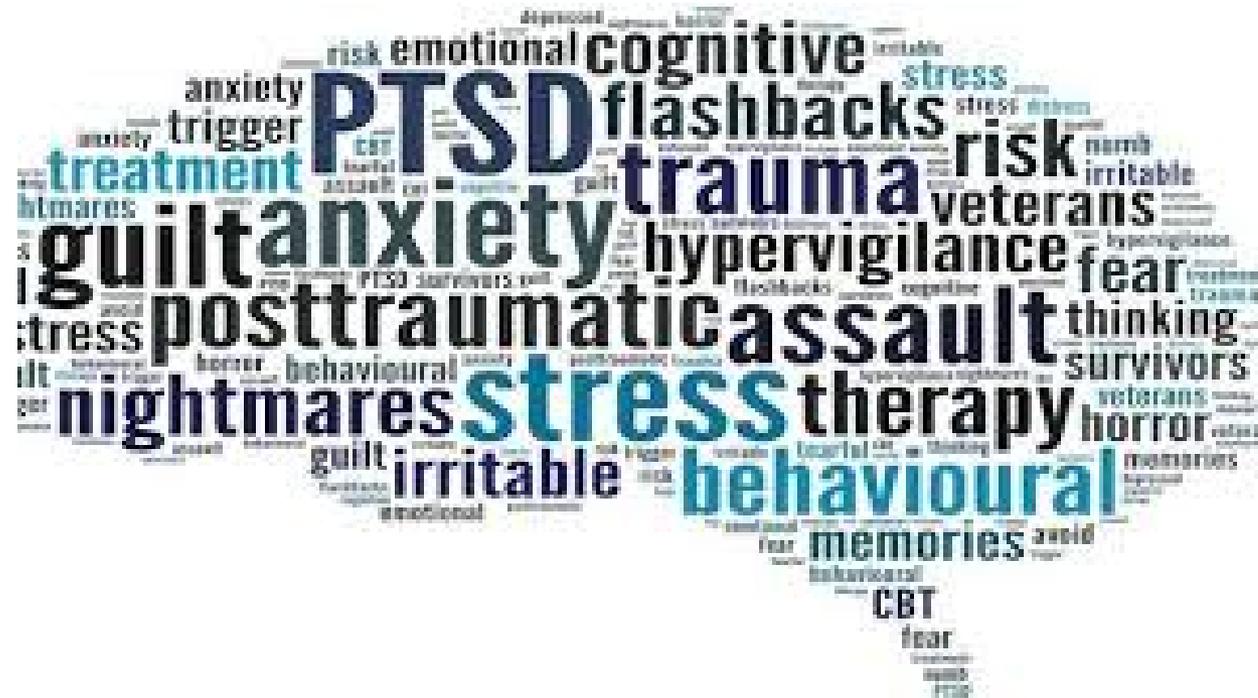
# SHAME



# Self-esteem

- ▶ You- “The best thing you can do for yourself is stop using drugs”
- ▶ Patient- “I don’t deserve the best, what else can I do?”

# Coping



# Visit openers:

**What have you done today to make the world a better place?**

**What have you done today to make today better than yesterday?**

**Give me an update for your fan club**



# What if ?

- ▶ **My patient's urine drug screen is positive for...**
  - ▶ **My patient's urine drug screen is negative for buprenorphine**
  - ▶ **My patient misses an appointment**
  - ▶ **My patient asks for a refill early**
  - ▶ **My patient has an overdose**
- 

# Recovery is about progression, not perfection

**Components of Recovery**



**Thank you...**



**Dr. Bob**



**Bill W.**