Primary Care-Based Buprenorphine Treatment for Opioid Use Disorder

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Brief History of Approach to SUD Tx in the US

- Countless soldiers, home from World War I, returned as heroin addicts
- Drug treatment clinics were swamped, then shut down by the Federal Government
  - Opioid addiction was considered a criminal offense, rather than a medical problem
  - Physicians were dissuaded from treating addiction from the 1920s until the 1970s.
- The Narcotic Addict Treatment Act of 1974 allowed physicians to treat opioid addicts with methadone in federal & state licensed facilities only

Drug Addiction Treatment Act (DATA) 2000

- Allows qualified clinicians to obtain a waiver and provide office-based medical treatment for opioid addiction

- In **2002** the FDA approved Suboxone and Subutex (buprenorphine) as treatment drugs for opioid addiction

- These fundamental changes in policy were created to change the way we view addiction

Buprenorphine: What is it?

- "Partial Agonist"
  - **Agonist**- chemical that binds to a receptor and activates the receptor to produce a biological response
- Strong bond at opioid receptor
- Slow rate of dissociation
  - Effects relatively durable

In other words…

- Buprenophine produces enough effect to prevent withdrawal (agonist)
- Effect is capped to limit “high” (partial)
- Slow metabolism of drug associated with reduced addiction potential

What about Suboxone?

- Suboxone is a trade name for a compound of buprenorphine & naloxone
- Naloxone is a “competitive antagonist”
  - **“Competitive”** means that it binds more strongly to receptors than full agonists (e.g. heroin, oxycodone, fentanyl)
  - **“Antagonist”** means that it blocks & dampens effect when binding to an opioid receptor
- When taken as designed (under the tongue), proportion of drugs (4:1) makes antagonist effect minimal
- If crushed & injected, naloxone effect is magnified, reducing agonist effect & possibly causing withdrawal

Evidence for accessible buprenorphine for OUD

- Primary Care-based buprenorphine prescriptions for OUD categorized as a “level I” treatment (Ducharme et al, 2012)
- In France, all physicians allowed to prescribe buprenorphine since 1995
  - 79% decrease in OD deaths in 6 years (Auriacombe et al, 2004)
- Bhatraju et al (2017) examined the efficacy of “low-threshold” buprenorphine care
  - Home inductions
  - Primary care-based prescriptions
  - No more than weekly visits
  - Counseling not compulsory
  - Treated 485 (305 new to bup) patients between 2006-2013
    - No serious adverse events reported
    - Retention rates for at least 1 wk= 83%

In Summary

- Buprenorphine is an effective choice for opioid use disorder
- When combined with naloxone (suboxone), it also contains a deterrent for cheating
- The DATA 2000 act allows clinicians to provide evidence-based treatment for patients in their community
  - Facilitates productive citizens
  - Encourages participation in treatment
  - Encourages comprehensive medical care

Our Project

- Empower primary care clinics to include use of buprenorphine for treatment of OUD as part of comprehensive primary care
  - Join OASAS colleagues in effort to stem opioid epidemic
  - Encourage a Harm Reduction perspective of treatment
  - Consider OUD as a chronic medical condition

Method

- October & November 2016: On-site training
  - Hired board certified addiction medicine psychiatrist Fall 2016
  - Psychologist embedded into primary care clinic
- Winter 2017: Embedded peer navigator in primary clinic
  - Also OASAS counselor
- January-December 2017: Weekly ECHO meetings
  - 1.5 hrs in duration
  - Expert “hub” connected to community “spokes”
  - 20-25 minute didactic session
  - Case presentations & discussion

Results to Date

- Five clinics including OUD as part of comprehensive care
- 18 primary care providers (including 4 APCs) with “Xs”
- Over 70 patients treated
- Increased collaboration between medical center & county CDCs

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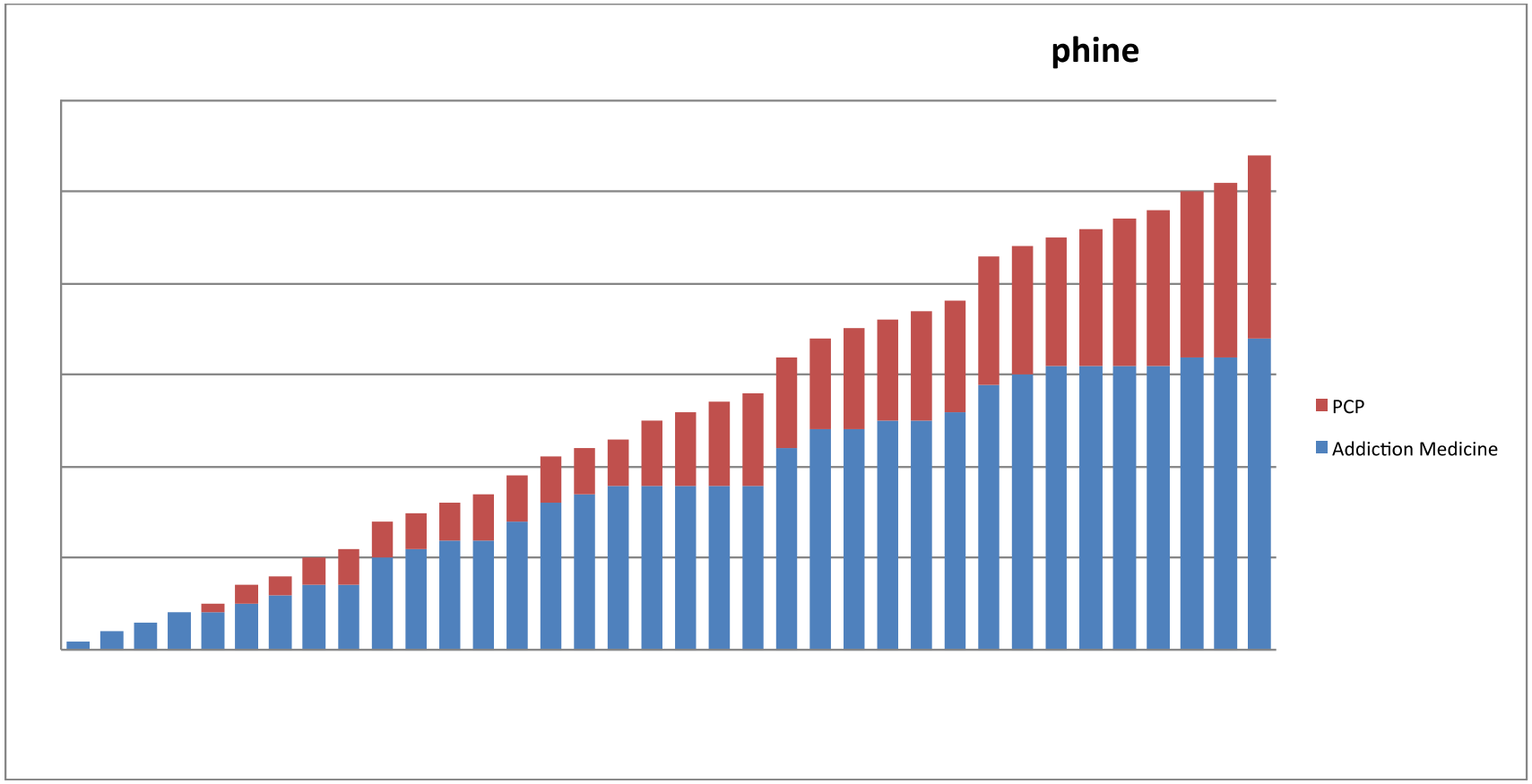
Progress w/ Office-Based MAT through May 2



Next steps

- Protocols for increased collaboration between CDCs and Primary Care
- Continued expansion of inclusion of OUD treatment as part of comprehensive primary care
- Expansion of integrated behavioral health services
- Collaboration with local law enforcement & drug courts

Statement from WHO

"Clinical research has proven that arbitrary limits on the use of methadone and buprenorphine therapy treatments is disadvantageous to the ultimate goals of judicial drug treatment programs. . . . While the legislature has the utmost respect for judicial discretion, ***it is evident that prohibiting the use of methadone and buprenorphine therapy treatment, or requiring its use … merely as a 'bridge to abstinence' is contrary to established best practices, and hinders the recovery process."***