Buprenorphine in the Treatment of Opioid Addiction: Reassessment 2010

SAMHSA & NIDA

Washington, DC

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Buprenorphine in the treatment of opioid addiction: a rural Appalachian experience 2003-2010

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OHIO
KENTUCKY
WEST VIRGINIA
VIRGINIA
MARYLAND
DELAWARE
TENNESSEE
NORTH CAROLINA
Chillicothe
Athens
Morgantown
Fairmont
Clarksburg
Parkersburg
Cumberland
Keyser
Martinsburg
Frederick
Aberdeen
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Charles Town
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Rockville
Annapolis
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Ravenswood
Weston
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Buchanan
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Bluefield
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Williamsburg
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Bedford
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Railroad
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40 mi

Kentucky—tobacco


NS
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316 600


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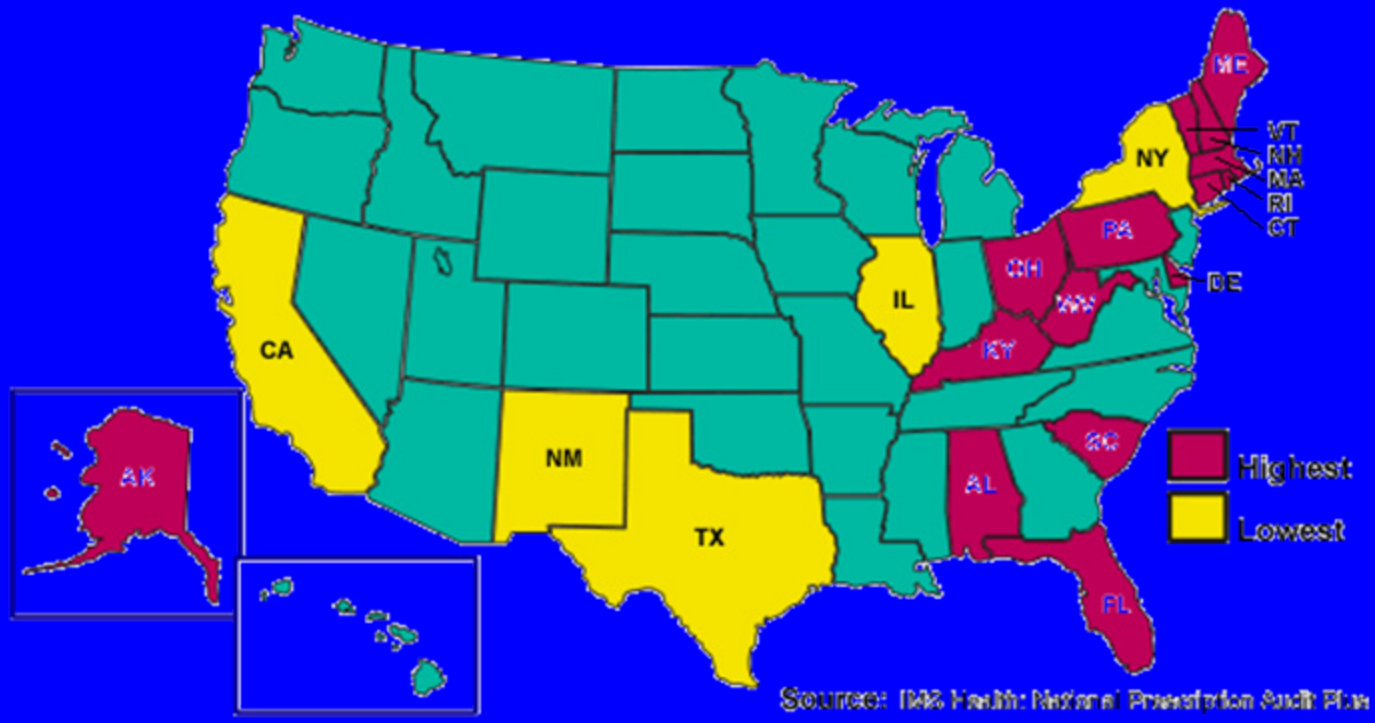
145901

Miners in St. Charles
circa 1949

OxyContin Prescriptions Per Capita: Highest and Lowest States for 2000



IMS Health

State of Virginia

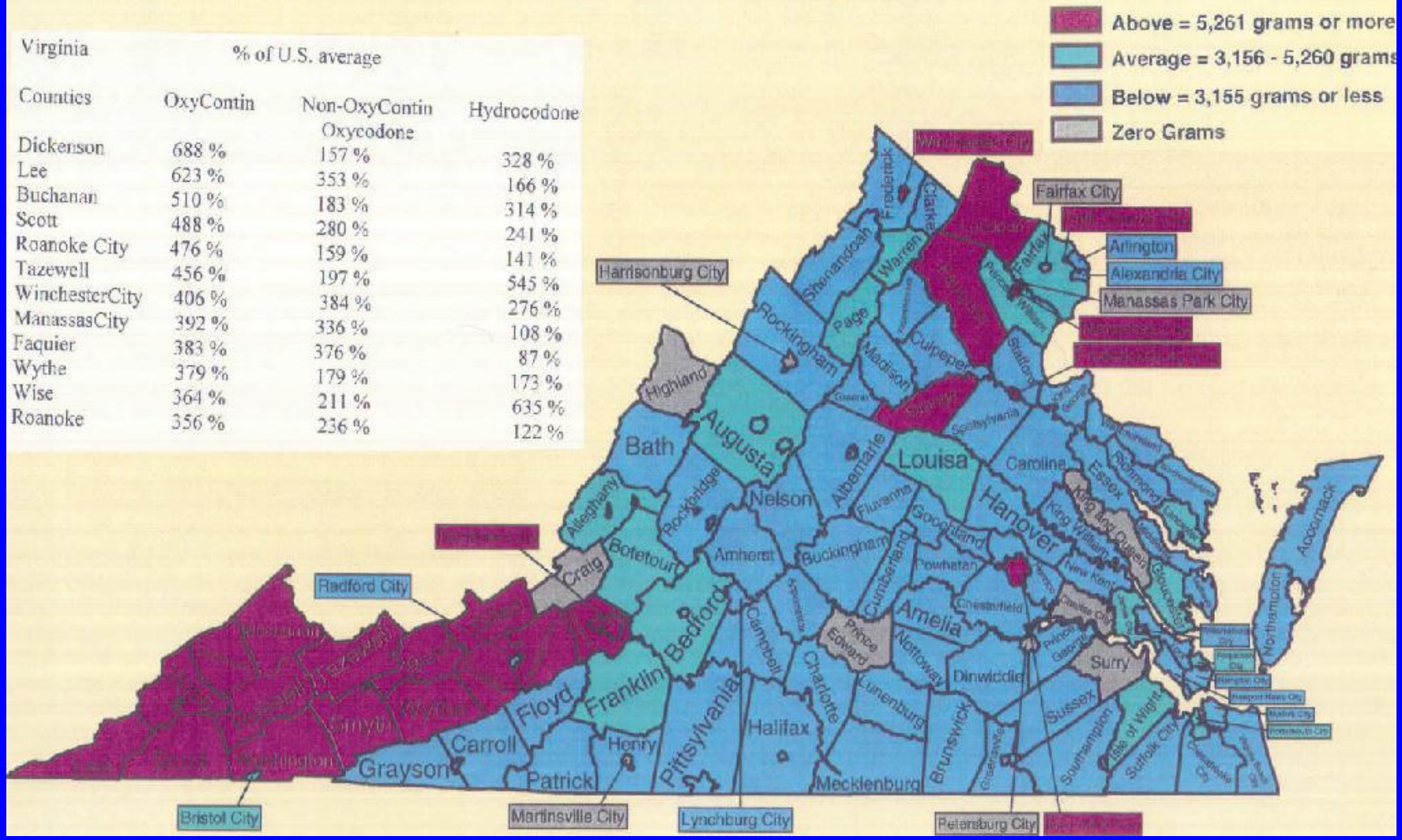
U.S. Average: **3,750 grams**

OxyContin Distribution per 100,000 Population

January - December, 2000

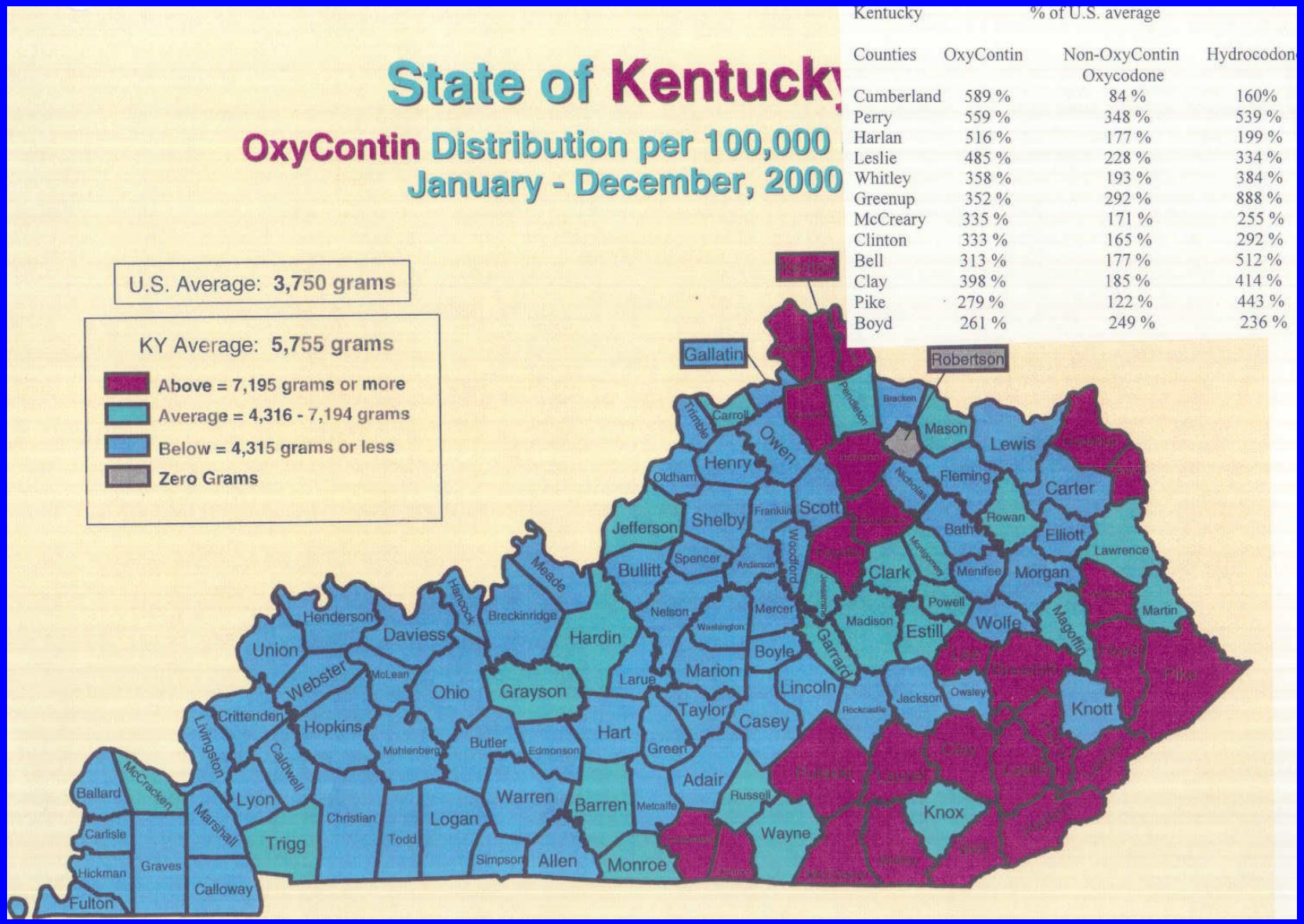
VA Average: **4,208 grams**

Virginia	% of U.S. average		
Counties	OxyContin	Non-OxyContin Oxycodone	Hydrocodone
Dickenson	688 %	157 %	328 %
Lee	623 %	353 %	166 %
Buchanan	510 %	183 %	314 %
Scott	488 %	280 %	241 %
Roanoke City	476 %	159 %	141 %
Tazewell	456 %	197 %	545 %
WinchesterCity	406 %	384 %	276 %
ManassasCity	392 %	336 %	108 %
Faquier	383 %	376 %	87 %
Wythe	379 %	179 %	173 %
Wise	364 %	211 %	635 %
Roanoke	356 %	236 %	122 %



State of Kentucky

OxyContin Distribution per 100,000
January - December, 2000

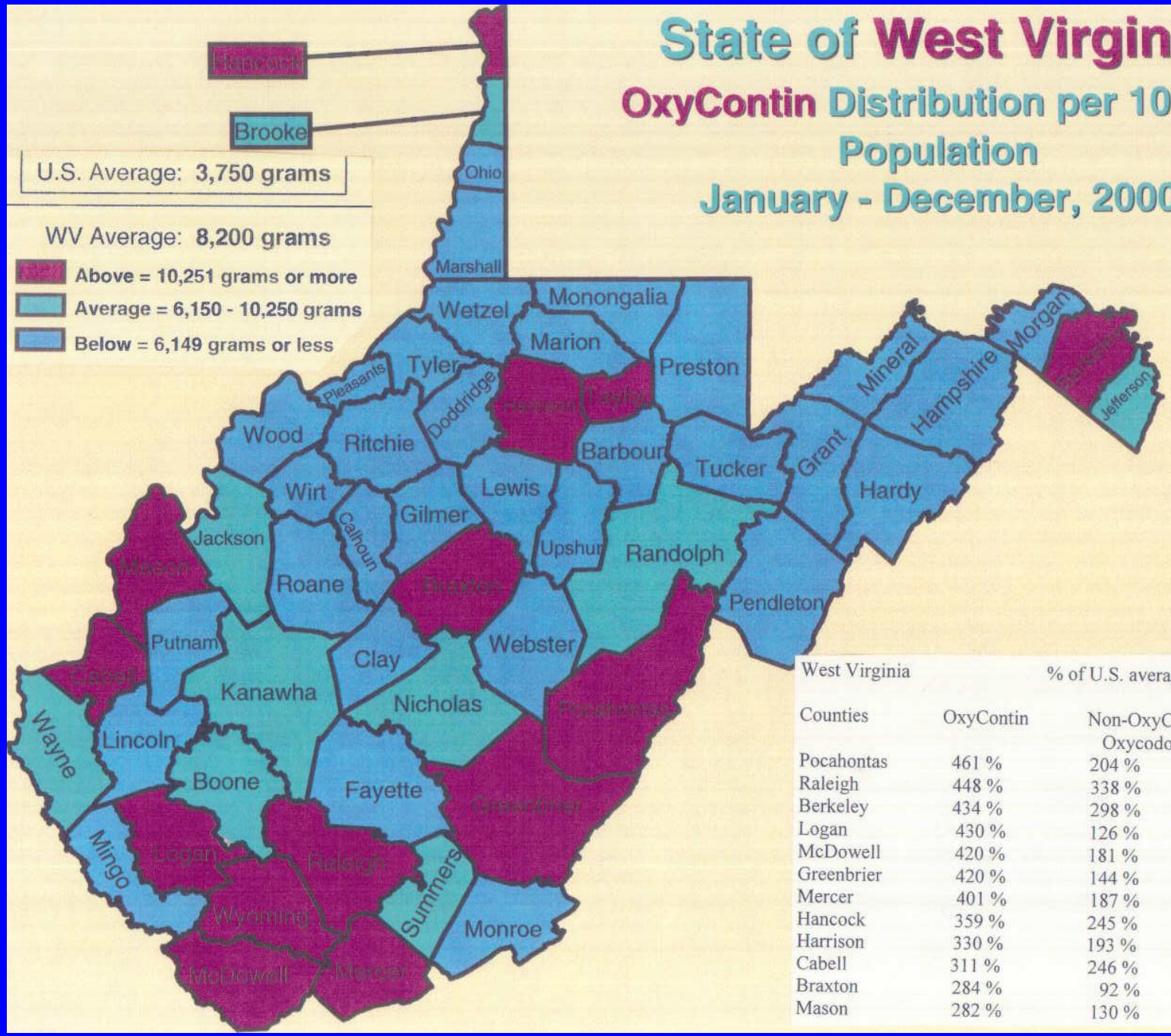


Kentucky		% of U.S. average	
Counties	OxyContin	Non-OxyContin Oxycodone	Hydrocodon
Cumberland	589 %	84 %	160%
Perry	559 %	348 %	539 %
Harlan	516 %	177 %	199 %
Leslie	485 %	228 %	334 %
Whitley	358 %	193 %	384 %
Greenup	352 %	292 %	888 %
McCreary	335 %	171 %	255 %
Clinton	333 %	165 %	292 %
Bell	313 %	177 %	512 %
Clay	398 %	185 %	414 %
Pike	279 %	122 %	443 %
Boyd	261 %	249 %	236 %

State of West Virginia

OxyContin Distribution per 100,000 Population

January - December, 2000



West Virginia Counties	% of U.S. average OxyContin	Non-OxyContin Oxycodone	Hydrocodone
Pocahontas	461 %	204 %	347 %
Raleigh	448 %	338 %	117 %
Berkeley	434 %	298 %	108 %
Logan	430 %	126 %	451 %
McDowell	420 %	181 %	476 %
Greenbrier	420 %	144 %	243 %
Mercer	401 %	187 %	416 %
Hancock	359 %	245 %	85 %
Harrison	330 %	193 %	248 %
Cabell	311 %	246 %	256 %
Braxton	284 %	92 %	260 %
Mason	282 %	130 %	249 %

Buprenorphine treatment program
Lee County, Virginia
2003-2010

**Challenges: poverty; transportation; ubiquitous prescription opiates
ubitiquitous drug community/contacts

**Advantages: community health clinic—sliding scale access
--Addiction Education Center—
--Sr. Beth Davies
--periodic team meetings
--"gold fish bowl" effect of rural small town life

Structure of the treatment program

---assessment and selectivity by AEC

---12 step meetings initiated

---assessment by physician

---signed contract

---induction

---frequent UDS: scheduled & random call in

---tight control of medication

---individual counseling & assessment

---continued reassessment in team meetings

Treatment program summary & results 2003-2010

--255 patients started on buprenorphine since 2.3.03

--almost exclusively a maintenance program

--98 patients in current program

2003------9

2004------7

2005------7

2006-----15

2007-----23

2008-----19

2009-----14

2010------4

Demographics

Men….47 Women…..51

Caucasian….all

Age….range 18-54 mean…31

working=42

SS disability=13

Full time single parent at home= 15

Unemployed, but could work = 18

In college = 10

Associated medical problems

Hepatitis C

Pregnancies

Diabetes mellitus, type I……1

Diabetes mellitus, type II……3

COPD……2

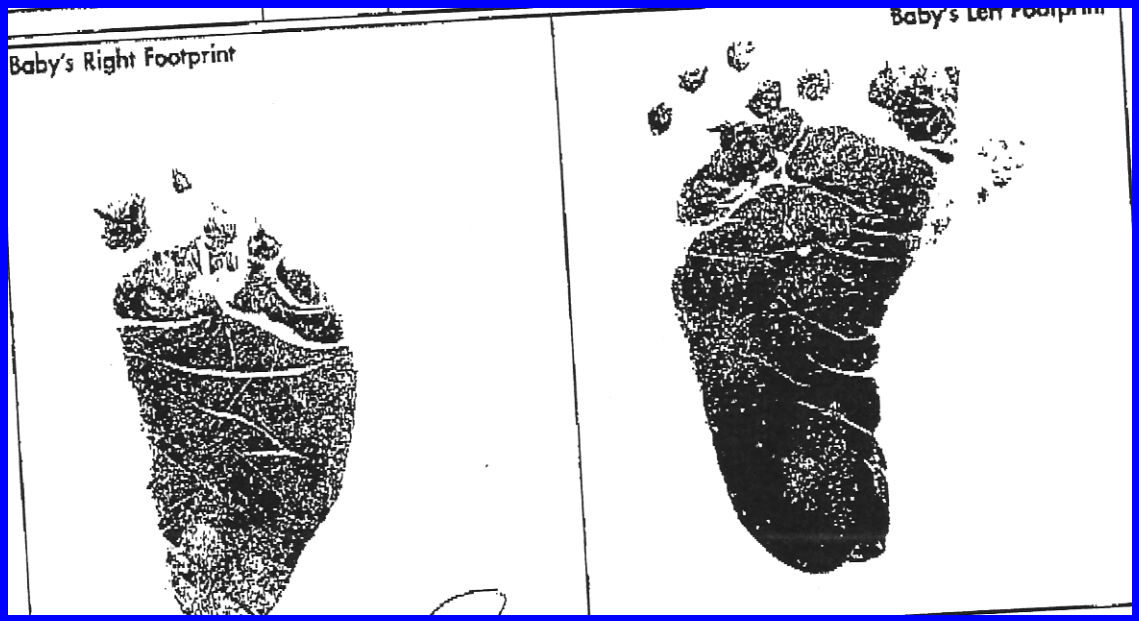
Generalized seizures……2

Crohn's disease……1

Schizophrenia, compensated……1

Endocarditis…… 3 episodes, 2 patients

Pregnancies--26



IVDA……..55(56%)

+ Hep C antibody….29 of 75

(38% of patients tested)

+ Hep C RNA..of 21 tested, 11 pos, 10 negative

HIV……..one

Drug of Choice(2003-2008)

OxyContin = 73 (76%)

hydrocodone = 11 (11%)

oxycodone/APAP= 5 (5%)

propoxyphene = 1

tramadol =1

heroin = 1

Insurance coverage

Commercial insurance	Medicaid	MC	SFS*	Self-pay
28	36	3	28	1

* = sliding fee scale at clinic--eg, $10 per visit

Suboxone/Subutex dose

for 96 patients in current program

24mgm = 7

20 mgm = 3

16 mgm = 49

12 mgm = 6

10 mgm = 2

8 mgm = 19

6 mgm = 5

4 mgm = 4

2 mgm = 2

Deaths--known

- 6 deaths in all pts who started program
- 2 deaths occurred while pt. in program
  --one overdose
  --one from medical problems

--4 deaths in patients who had left the program or had been discharged

Urine drug screening 2003-2008

Total # UDS	negative for all substances	opioid negative
5,883	4,922 (83%)	5,627 (95%)

Clinical estimate of success—Feb., 2010

++++= drug free; meetings; early recovery =21

+++ = drug free; not meeting involved; = 47

++ = intermittent drug use, but much improved from pre-treatment =12

\+ = doing poorly; frequent use; little meeting involvement = 7

Can’t tell or too early = 11

Current problems in buprenorphine treatment in Central Appalachia

--Increasing diversion; street drug now

--commercialization of buprenorphine treatment

---high charges, cash, no insurance

---limited physician time spent with patient

---infrequent accountability (UDS)

---excessive dosage prescribing

---frequently, prescribed with alprazolam

Possible Responses to the buprenorphine diversion problem

Responses to the buprenorphine diversion problem

CHANGING THE MARKET PLACE HEALTH CARE SYSTEM

Possible responses (cont)

- Training programs (cont)
  --emphasis on observed dosing &
  tight control of meds
  --emphasis on frequent UDS
  --emphasis on avoidance of
  BENZODIAZEPINES
  --emphasis on dosing limits
  --12 step program involvement

Responses (cont)

- EDUCATIONAL INITIATIVES

  eg, “Best practices in buprenorphine prescribing..”

Responses (cont)

- More intensive promotion of

PCSS

and best practices at the web-site

eg,

--update the “Management of Psychiatric Medications in Patients receiving buprenorphine/naloxone” (last up-dated 4/17/06)

--highlight PCSS Guidance “Adherence, Diversion, & Misuse of Sublingual Buprenorphine”

Responses (cont)

- SAMHSA/CSAT initiatives
- Using IMS prescribing data, target physicians for educational intervention that are outliers (excessive prescribers, prescribers of alprazolam with bup, etc)

Possible Responses (cont)
A short & sweet flier

- Tight control of medication (family member, etc)
- Observed ingestion
- Accountability—frequent UDS, at least initially
- Dosing limits: green, orange, red
- Limited quantity prescribed—at least initially
- Pill counts
- Random observed UDS
- Limitation of mono-prep for pregnancy
- Avoidance of benzos
- Guidance for the patient with benzo & opioid dependence; referral to PCSS

Possible responses (cont)

- SAMHSA/CSAT initiative to promote best buprenorphine prescribing practices through contact with:

  (1) State Medical Boards;
  (2) Medicaid;
  (3) Managed care—pharmaceutical benefits companies

Responses (cont)

CSAT/SAMHSA ALLIANCE WITH COMMUNITY HEALTH CENTERS TO PROMOTE EXPANSION OF BUPRENORPHINE TREATMENT

--1,250 CHC nationwide

--serve 20 million Americans

--rural & urban underserved

Responses (cont)

Automatic regulatory agency review for any physicians buprenorphine practice exceeding a pre-set # of patients—40 ?

--weighing the possible positive impact in affecting poor prescribing practices VS negative impact on good prescribing docs

THANK YOU!

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