CIAO Time Presents:

Buprenorphine

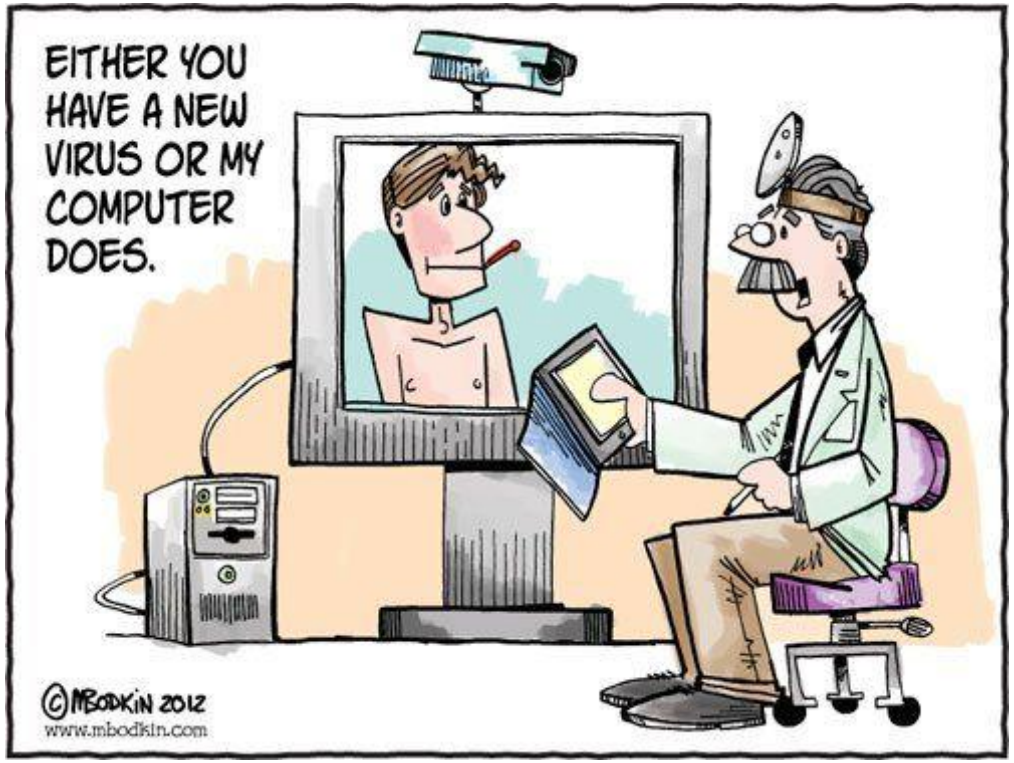
The Center for Innovation in Academic Detailing on Opioids

San Francisco Department of Public Health

Agenda

1. Introduction to CIAO
2. **Case Study:** Tele-buprenorphine
3. **Activity:** Mock academic detailing visit on buprenorphine
4. Questions & Answers

Please submit questions in the Chat!



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The Center for Innovation in Academic Detailing on Opioids

Our vision: We aim to decrease opioid-related morbidity and mortality by promoting balanced approaches to opioid management.

Our mission: We collaborate with healthcare providers to improve opioid and chronic pain-related care through innovative training and technical assistance services.

CENTER FOR INNOVATION IN ACADEMIC DETAILING ON OPIOIDS

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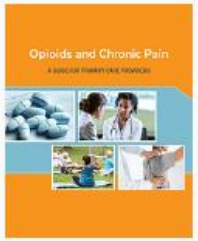
Our materials

CIAO's educational materials were developed by the San Francisco Department of Public Health and reviewed by a panel of experts. Materials are regularly updated to include new scientific literature and changes in policy and programming.

Our materials are meant to be used and shared! If you are interested in using, adapting, or learning more about our materials, please fill out our contact form.



Opioids and Chronic Pain: A guide for primary care providers

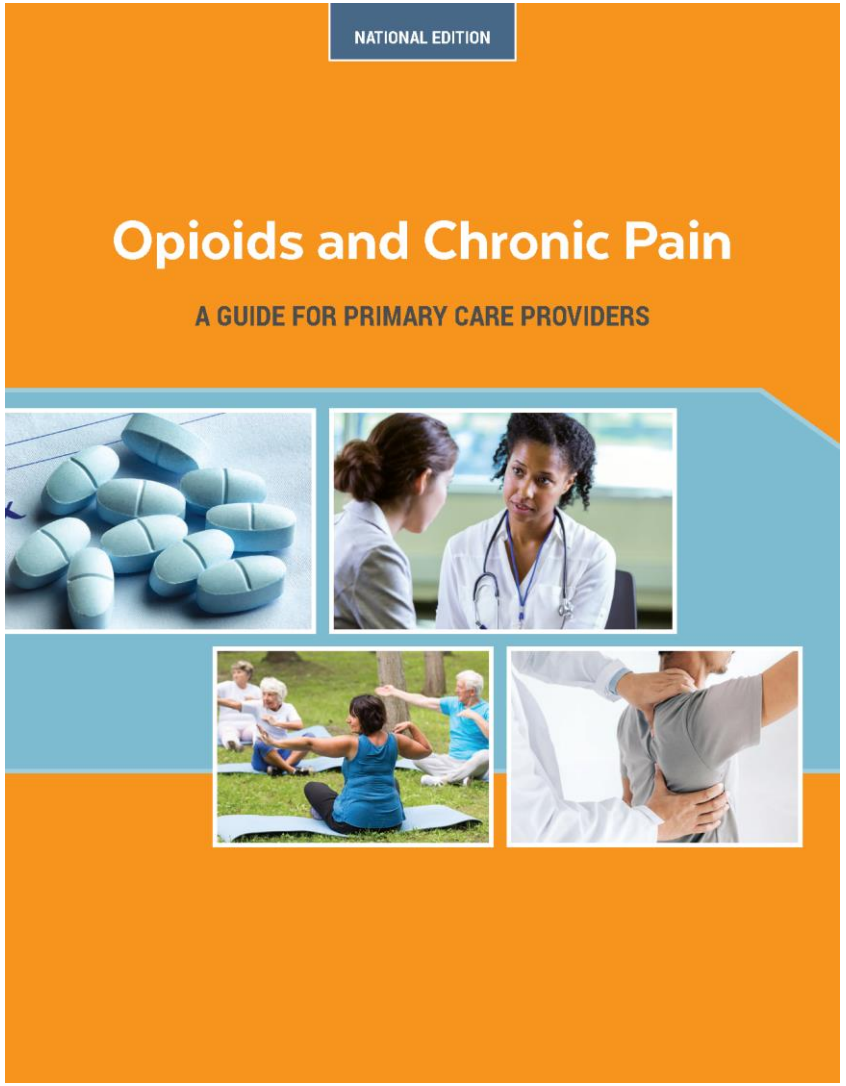
California edition
National edition

CIAO's Academic Detailing and Technical Assistance Services (PDF)

Managing Chronic Non-Cancer Pain Poster

California edition
National edition

California Pharmacists and Furnishing Naloxone: What you need to know (PDF)



View more of our academic detailing materials at **www.ciaosf.org/materials**

Case Study: Introduction

The patient:

- 30-year-old male with **severe opioid use disorder** and **experiencing homelessness** shows up at a syringe exchange program during shelter-in-place.
  - Injects fentanyl and heroin daily
  - Has taken buprenorphine in the past
- Wants help to **avoid opioid withdrawal** if COVID-19 lockdowns limit drug supply.

However, there are ***no medical providers on site.***

- The harm reduction counselor remembers that telehealth might help.

(Harris et al, 2020)

Definitions

- **Opioid use disorder (OUD)**: a problematic pattern of opioid use leading to problems or distress over a 12-month period
- **Buprenorphine (most common brand name Suboxone®)**: a prescription medication that treats opioid use disorder through its activity as a partial opioid agonist
  - Must be prescribed by someone with a DATA 2000 waiver (X waiver)
- **Buprenorphine induction/initiation**: starting a patient on buprenorphine either at home or in a medically-monitored clinic or hospital setting

Does telehealth work for buprenorphine?

Before COVID-19:

- A non-randomized study in the VA showed that buprenorphine induction via telehealth can be **conducted safely** and potentially **increase access** to buprenorphine in rural communities *(Brunet et al, 2019)*

During COVID-19:

- A telemedicine buprenorphine clinic in New York City induced 78 patients between March-May 2020. 8 weeks later:
  - 54% remained in care, 27% transferred to a community treatment program, 20% were lost to follow up *(Tofighi et al, 2021)*
- An addiction telehealth program in San Francisco used a telephone-based program to start patients on buprenorphine in Isolation and Quarantine hotels.
  - 12 patients were identified with newly diagnosed OUD and started buprenorphine
  - 58% had never been prescribed medications for OUD *(Mehtani et al, 2021)*

Buprenorphine Prescribing via Telehealth

SAMHSA
Substance Abuse and Mental Health Services Administration

Updated April 21, 2020

FAQs: Provision of methadone and buprenorphine for the treatment of Opioid Use Disorder in the COVID-19 emergency

- **March 31, 2020:** clinicians with a DATA 2000 waiver outside of Opioid Treatment Programs can prescribe buprenorphine to new *and* existing patients with opioid use disorder via telehealth (including telephone if necessary)
  - As long as an adequate evaluation can be accomplished via telephone
  - Under 21 U.S.C. § 823(g)(2), and 42 C.F.R. Part 8, as applicable

Case Study: Patient History

The harm reduction counselor calls a buprenorphine-waivered primary care provider via facetime to conduct a telemedicine visit.

The primary care MD obtains the following patient history via video conference:

- Injects 2 grams of fentanyl/heroin daily
- Uses **non-prescribed benzodiazepines** as well as **methamphetamine and cocaine**
- History of non-fatal overdoses and documented severe OUD and stimulant use disorder
- **Previous treatment:**
  - Methadone
  - Naltrexone
  - Buprenorphine/naloxone that was interrupted by recent incarceration and relapse 2 months ago

First Poll

What is the BEST next step for this patient's primary care provider in treating the patient's OUD?

1. **Prescribe buprenorphine and educate about home induction via telemedicine.**
2. Referral to methadone maintenance.
3. Prescribe naloxone and counsel patient to stop using other substances before considering buprenorphine.
4. Send the patient to the hospital or to an opioid treatment program since he is using benzodiazepines.

Buprenorphine FAQ

Nearly **80% of people with an opioid use disorder do not get medications** like buprenorphine or methadone to treat OUD

- We need a larger pool of prescribers

Deaths due to buprenorphine are rare, and generally involve multiple medications

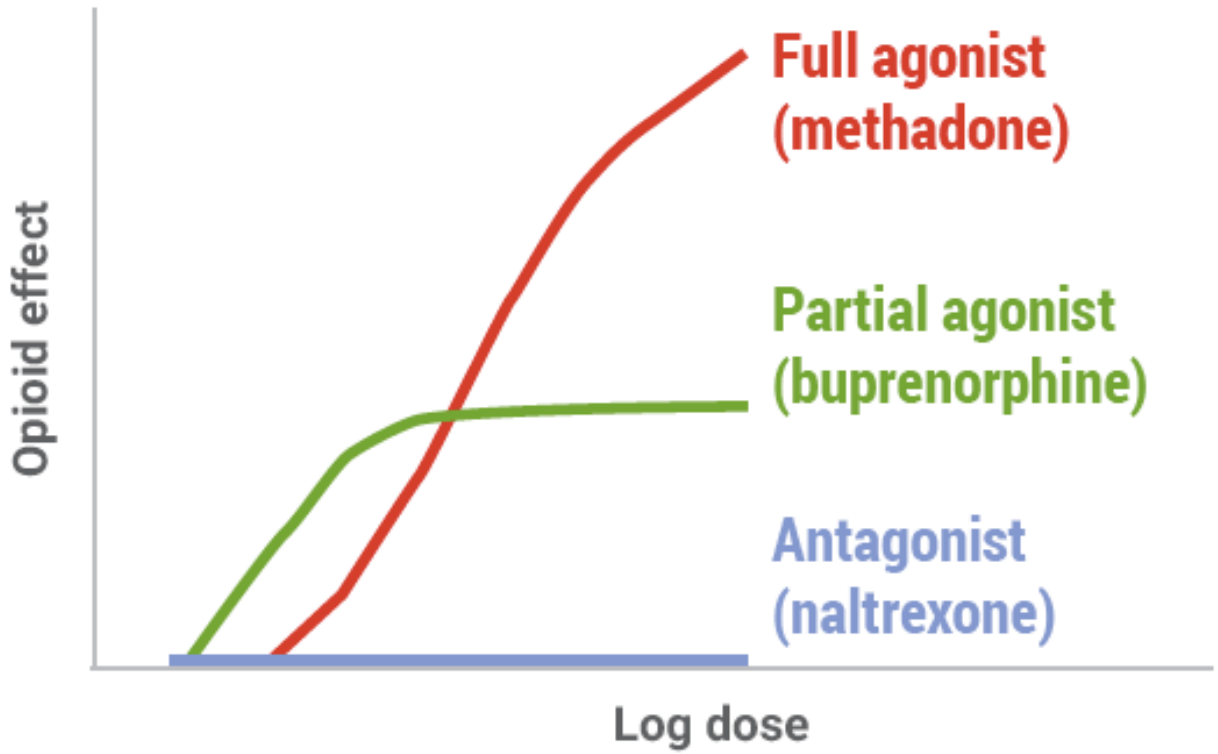
- Buprenorphine is **much safer** than full opioid agonists

Maintenance treatment with buprenorphine **cuts all-cause mortality by ~50%**

- It also improves social functioning, lowers rates of illicit substance use, and reduces risk of HIV and HCV

Kimber et al, 2015; Pierce et al, 2016; Schuckit, 2016

Buprenorphine overview and safety profile



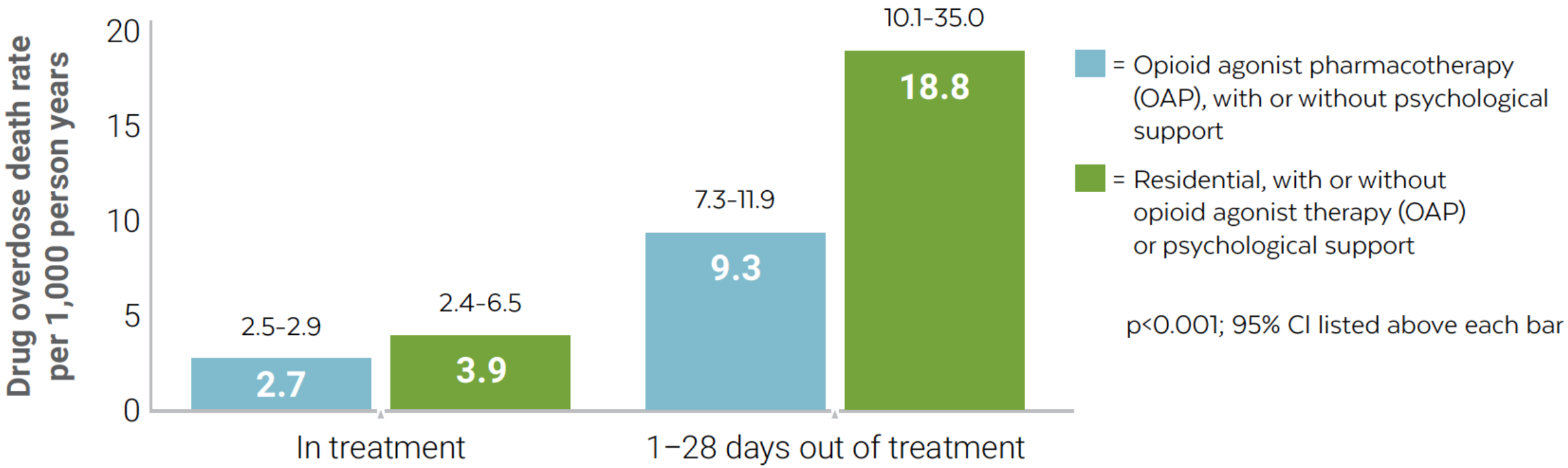
BUPRENORPHINE

- A partial opioid agonist
- Time to peak: 30 min to 3 days depending on formulation
- Has very high affinity, blocking effects of heroin or other opioids

SAFETY PROFILE

- Due to the "ceiling effect" of a partial agonist, buprenorphine has:
  - **Low potential for misuse** and diversion
  - **Low risk** of respiratory depression or overdose
  - **Ability to reduce craving and withdrawal** without the euphoria of full agonist
- Maintenance is critical: OUD requires long-term care.
- Buprenorphine treatment is safe and effective during pregnancy.[25]
- Most buprenorphine for OUD treatment is co-formulated with naloxone to discourage diversion or injection of the product.

DRUG OVERDOSE DEATH RATE PER 1,000 PERSON YEARS AMONG 151,983 PEOPLE WITH OUD SEEKING TREATMENT IN THE UNITED KINGDOM[24]



Pierce et al, 2016

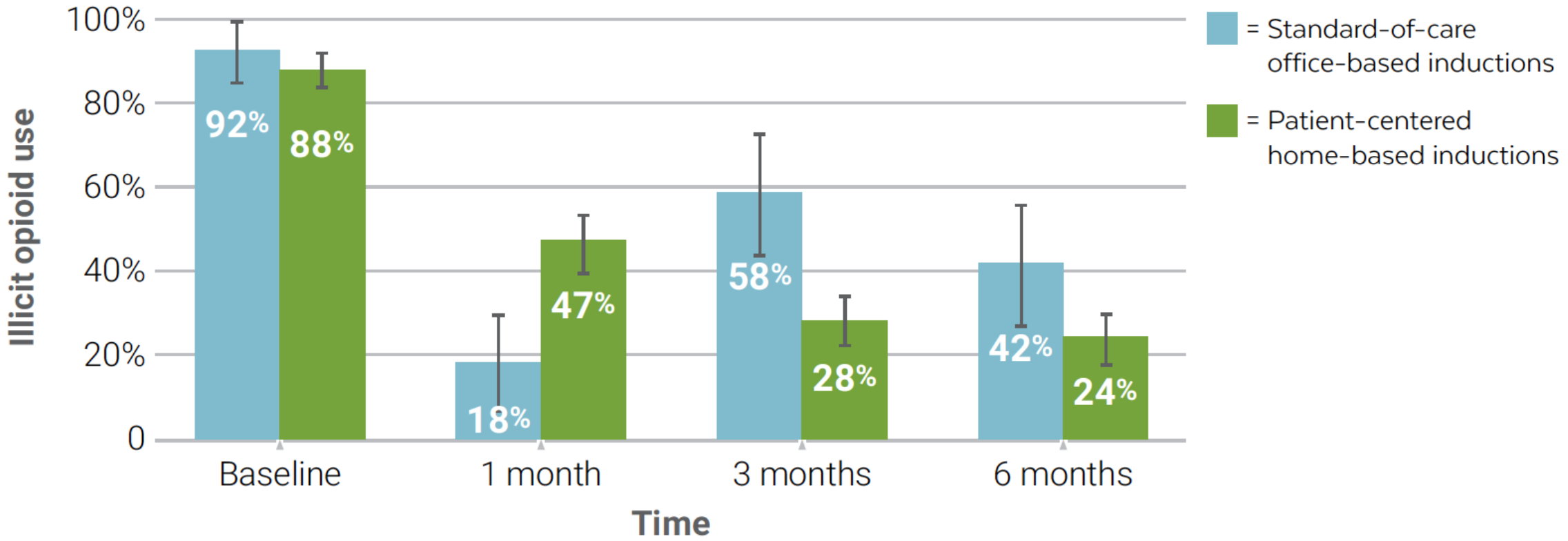
FDA Drug Safety Communication: FDA urges caution about withholding opioid addiction medications from patients taking benzodiazepines or CNS depressants: careful medication management can reduce risks

Safety Announcement

[9-20-2017] Based on our additional review, the U.S. Food and Drug Administration (FDA) is advising that the opioid addiction medications buprenorphine and methadone should not be withheld from patients taking benzodiazepines or other drugs that depress the central nervous system (CNS). The combined use of these drugs increases the risk of serious side effects; however, the harm caused by untreated opioid addiction can outweigh these risks. Careful medication management by health care professionals can reduce these risks. We are requiring this information to be added to the buprenorphine and methadone drug labels along with detailed recommendations for minimizing the use of medication-assisted treatment (MAT) drugs and benzodiazepines together.

PATIENTS CAN BE STARTED ON BUPRENORPHINE IN THE OFFICE *OR* AT HOME

Reductions in opioid use are similar when patients start therapy themselves at home compared to office-based settings.[28]



Cunningham et at, 2011

Case Study: Telemedicine Visit

During the video call, the patient appears alert and well-appearing.

From his chart:

- **One week ago**: HIV screening non-reactive
- **6 months ago**: Urine drug screening positive for fentanyl, cocaine, and methamphetamine
- Patient has been on buprenorphine/naloxone before at **8/2mg twice a day (total daily dose = 16/4mg)**.

Second Poll

The provider can safely restart the patient on buprenorphine via a home induction at the same dose he had been on prior. True or false?

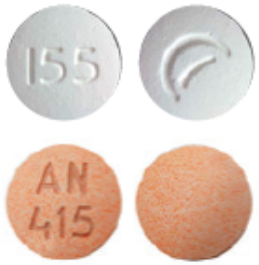
1. **True**
2. False

Managing Opioid Use Disorder: Prescribing buprenorphine

Formulations

- Keep buprenorphine tablet or film under tongue until dissolved (5-15 min). **DO NOT SWALLOW.**
- OK to cut film in half or quarter pieces.
- Therapy usually involves buprenorphine with naloxone, although the monoformulated product can also be used.

BUPRENORPHINE/NALOXONE (CO-FORMULATED)



Sublingual tablets

Sublingual film

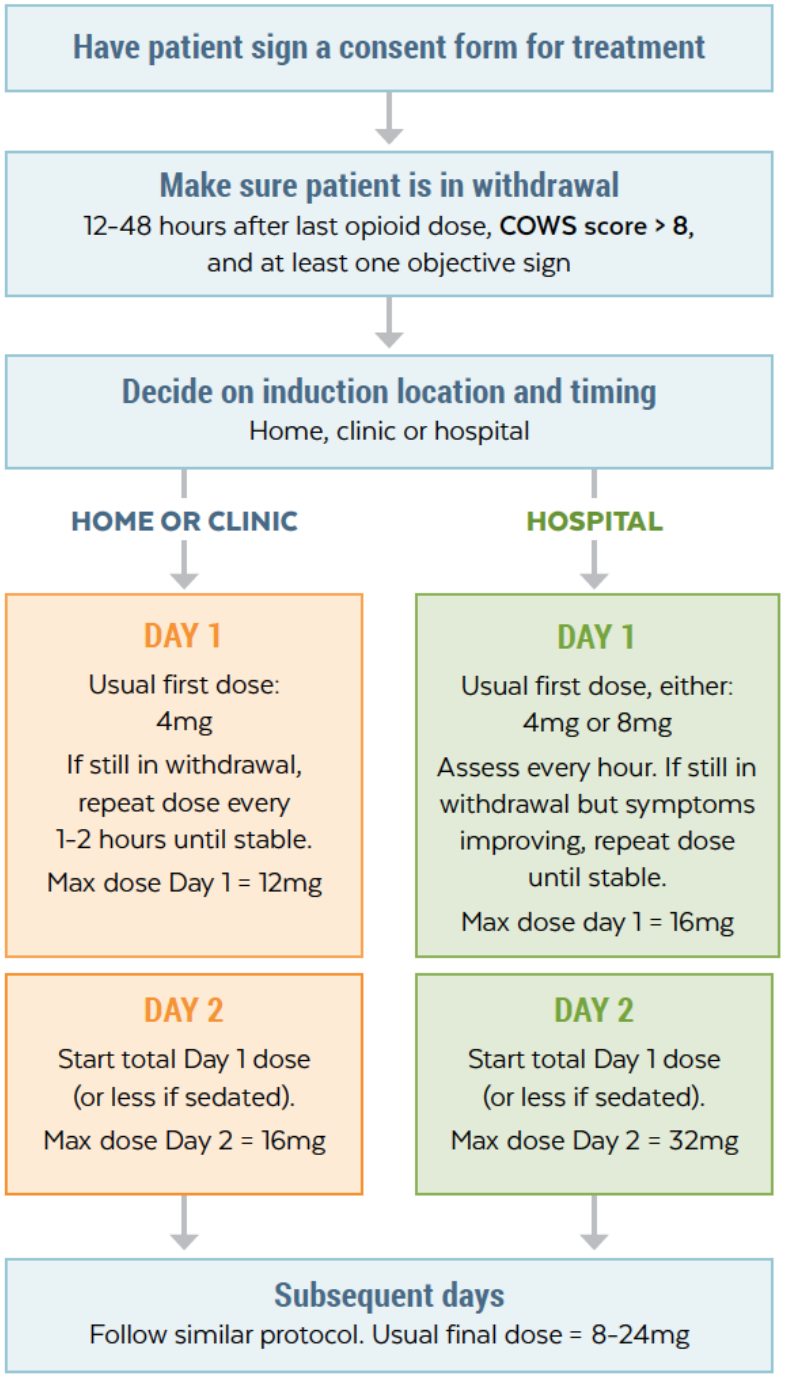
MONOFORMULATED BUPRENORPHINE

Sublingual tablets

Subcutaneous injection

Transdermal patch

Starting buprenorphine



✓ **CHECK COWS:**

Higher score = less risk of precipitated withdrawal

Clinical Opioid Withdrawal Scale (COWS): mdcalc.com/cows-score-opiate-withdrawal

COWS has 11 items and up to 48 points.

Look for subjective symptoms AND at least one objective sign.

- **Subjective**: insomnia, vomiting, diarrhea, restlessness, anxiety, abdominal cramps, diaphoresis, myalgias/arthralgias, hot flashes, dizziness, tearing, goosebumps, shaking, yawning, twitching, sweating
- **Objective**: restlessness, shivering, rhinorrhea, dilated pupils, tachycardia, yawning, piloerection, tremor, sweating, hypertension

Starting Buprenorphine

A Guide for Starting Medications at Home

Clinic Contact Info

Day 1: Are You Ready?

Wait until other opioids are processed by your body and you are in withdrawal before starting buprenorphine. Only start taking buprenorphine once **both** of the following are true:

1. **Timing:** Wait at least 12 hours since you last took heroin or pain pills (oxycodone, hydrocodone). Do not continue if you have recently taken methadone, as you will need to take your first dose in the clinic.

   Time of last opioid dose: _____. **Time of first buprenorphine dose:** _____.

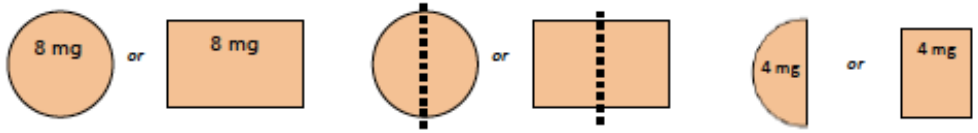
2. **Symptoms:** You should have at least 3 of the following symptoms, showing that you are in withdrawal:

- Shaking or tremors
- Joint and bone aches
- Chills or sweating
- Anxiety or irritability
- Goosebumps
- Nausea or Vomiting
- Heavy yawning
- Enlarged pupils
- Diarrhea

Use the symptom management guide if you have been prescribed medications for withdrawal.

First Dose

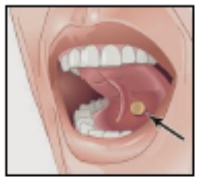
Your first dose should be 4 mg of buprenorphine, which is **half** of a tablet or film.



1. Start with a full tablet or film
2. Cut that tablet or film in half
3. This is your first dose

Taking Your First Dose

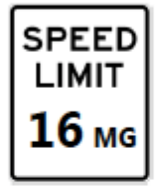
This medication only works when it is taken under the tongue in the following way:



1. Put the first dose **under your tongue**. Do not swallow it—the medication won't work!
2. Keep the medication there for **15 minutes**. Do not eat food or drink liquids for **30 minutes** afterwards.
3. **Check in at 1 hour**. If you still feel bad, put the other half-tablet or half-film (4 mg) under your tongue.

For the Rest of Day 1

During the first day, keep checking in to see how you feel.



1. **Check every 3 to 6 hours** to see how you feel. If you feel fine, don't take any more medications. If you have withdrawal, take another 4 mg (half-tablet or half-film) under your tongue.
2. **Do not take more than 16 mg on the first day** of buprenorphine (2 full tablets or films). If you feel really bad (such as an ever worse withdrawal) after starting medications, go to the emergency department.
3. **Note the following:**

   How much medication did I take on Day 1? _____.

   When is my next appointment? _____.

Day 2 and Onward

Plan to take some medication every day. Do not wait until you are in withdrawal again to take medication on Day 2 and onward. You should be able to stay comfortable.

1. **Check in when you wake up**. If you feel fine, take the same amount of medication that you took on the previous day. **If you don't feel well, you may need to change your dose.**
2. **Changing your dose:** If you feel like you're in withdrawal, you may need a higher dose. If that's the case, take the amount you took the day before and add another 4 mg (half-tablet or half-film) to that dose. If you're too sleepy, lower your dose by 4 mg.
3. **Do not take more than 24 mg of medication on any day** (3 full tablets or films). If you need more than 2 tablets or films daily or have a hard time getting comfortable, call our clinic for help. If you are very sick, go to the emergency room.

Come Back to Our Clinic

We want to check in with you while you start medications to make sure that you are doing well!

Location:	Date/Time:	Clinic Contact Info

Guide originally created at Highland Hospital in Oakland, California. Contact David Tian at datian@alamedahealthsystem.com with feedback.

Indications for naloxone prescribing

CDC recommends

- Prescribing naloxone for patients on prescribed opioids with:
  - Opioid use ≥50 MMEs/day
  - Benzodiazepine use
  - History of substance use disorder
  - History of opioid overdose
  - Other factors that increase overdose risk, including comorbidities or concomitant medications

Also offer naloxone to patients:

- With any illicit substance use
- At risk of witnessing an opioid overdose

Case Study

The patient receives:

- A prescription for a 1-week supply of **buprenorphine sublingual films.**
  - 1-week supply given since the patient is unhoused and has no safe place to store the medication.
- **Nasal naloxone** at the harm reduction center.
- Education about home induction.

Next steps:

- See the patient 1 week later via videoconferencing at the harm reduction clinic.

Third Poll

What else should eventually be part of the patient's treatment plan for opioid use disorder? Select all that apply.

1. Housing
2. Healthcare maintenance
3. Determining frequency of refills
4. Addressing benzodiazepine use
5. Urine drug screening

Continuing buprenorphine

- **Document OUD in chart.**
- **Optimal dose varies by patient.** ≥16mg/day may aid in retention, block other opioids, and reduce relapse, pain, and dysphoria.
- **Follow-up visits**: tailor frequency to patient stability. Weekly visits at start of treatment or when unstable; monthly or longer when stable.

  Review:
  - Buprenorphine adherence, illicit opioid use, UDS, CSMP
  - Mental health and comorbid substance use disorders
  - Healthcare maintenance
- If unsuccessful, consider other OUD medications such as methadone or extended-release naltrexone.

Remember that buprenorphine:

- **Gives patients control** over opioid use.
- **Lowers overdose risk,** even if still using illicit opioids, by binding very tightly to μ receptors.
- **Does not treat other substance use disorders.**

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Substance Use Warmline

Free, Confidential Clinician-to-Clinician Consultation on Substance Use Evaluation and Management

855-300-3595 (M – F, 9am – 8pm EST), or nccc.ucsf.edu

Our consultants provide clinicians with guidance on a range of topics, including:

- Assessing and treating opioid, alcohol, and other substance use disorders
- When/how to initiate medications for opioid use disorder
- Toxicology testing: when to use it and what it means
- Identifying and managing withdrawal
- Approaches to adjust opioid-based pain regimens to reduce risk of misuse and harm
- Harm reduction and overdose prevention strategies
- Discuss useful communication and care strategies to support patients living with, or at risk for, substance use disorders
- Substance use in special populations

Our team includes expert physicians, pharmacists, and advanced practice nurses with considerable experience managing substance use disorder. *No protected health information is collected during our consultations.*

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1OHA30039 (AIDS Education and Training Centers National Clinician Consultation Center) in partnership with the HRSA HIV/AIDS Bureau (HAB) and Bureau of Primary Health Care (BPHC), awarded to the University of California, San Francisco

Case Study: Telemedicine Visit

During the scheduled telemedicine visit 1 week later, the patient reports his last heroin/fentanyl dose was 6 days ago.

He is now back on **8/2mg buprenorphine/naloxone twice a day** with no withdrawal symptoms or cravings.

Next steps:

You prescribe a **2-week supply of buprenorphine/naloxone** for him and agree to have an **in-person visit** once the pandemic risks decrease or if he is struggling with his treatment.

Key Messages for Academic Detailing on Buprenorphine

- Buprenorphine is **safer than full agonists** due to the ceiling effect on respiratory depression.
- Telehealth can be used to **start and continue patients** on buprenorphine.
  - Providers can provide electronic refills of buprenorphine to patients without urine drug screening or in-person visits.

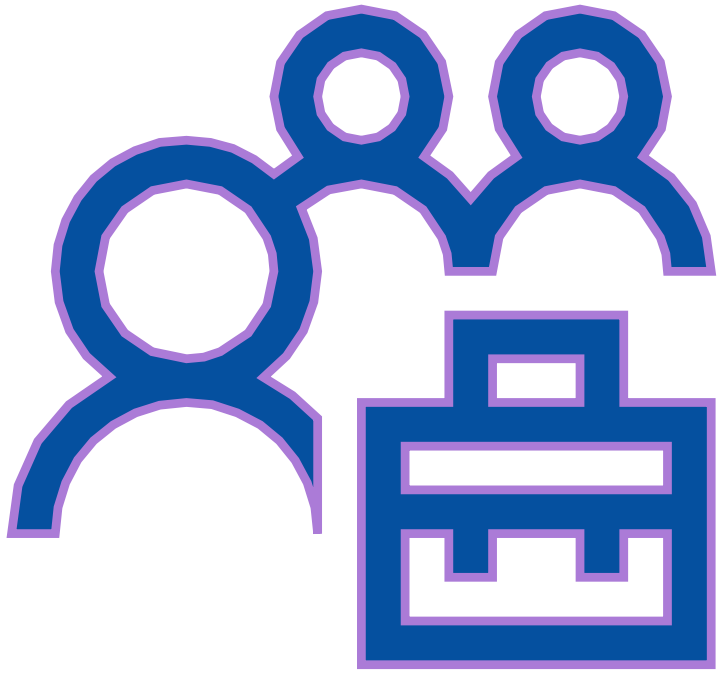
Patients should not be refused buprenorphine because they use other substances.
Buprenorphine is safer than any street opioids.

Mock Academic Detailing Visit

What to watch for...

Steps of a Visit

- Introduction
- Needs Assessment
- Key Messages
- Handling Objections
- Summary & Closing



Mock Academic Detailing Visit

References

- Brunet N, Moore DT, Lendvai Wischik D, Mattocks KM, Rosen MI. Increasing buprenorphine access for veterans with opioid use disorder in rural clinics using telemedicine. Subst Abus. 2020 Feb 20:1-8. doi: 10.1080/08897077.2020.1728466. Epub ahead of print. PMID: 32078492.
- Cunningham CO, Giovanniello A, Li X, Kunins HV, Roose RJ, Sohler NL. A comparison of buprenorphine induction strategies: patientcentered home-based inductions versus standard-of-care office-based inductions. J Subst Abuse Treat. 2011;40(4):349–356. Doi.org/10.1016/j.jsat.2010.12.002
- Harris M, Johnson S, Mackin S, Saitz R, Walley AY, Taylor JL. Low Barrier Tele-Buprenorphine in the Time of COVID-19: A Case Report. *J Addict Med*. 2020;14(4):e136-e138. doi:10.1097/ADM.0000000000000682
- Kimber et al, 2015. "Mortality Risk of Opioid Substitution Therapy with Methadone Versus Buprenorphine: A Retrospective Cohort Study," Lancet Psychiatry 2, no. 10 (2015): 901–8, doi:10.1016/ S2215-0366(15)00366-1
- Mehtani NJ, Ristau JT, Snyder H,Surlyn C, Eveland J, Smith-Bernardin S & Knight KR (2021) COVID-19: A catalyst for change in telehealth service delivery for opioid use disorder management, Substance Abuse, DOI: 10.1080/08897077.2021.1890676
- Pierce M, Bird SM, Hickman M, et al. Impact of treatment for opioid dependence on fatal drug-related poisoning: a national cohort study in England. Addiction. 2016;111(2):298–308. Doi.org/10.1111/add.13193
- Schuckit MA. "Treatment of Opioid-Use Disorders," New England Journal of Medicine 375 (July 28, 2016): 357–68, doi:10.1056/NEJMra1604339
- Tofighi B, McNeely J, Walzer D, Fansiwala K, Demner A, Chaudhury CS, Subudhi I, Schatz D, Reed T, Krawczyk N. A Telemedicine Buprenorphine Clinic to Serve New York City: Initial Evaluation of the NYC Public Hospital System's Initiative to Expand Treatment Access during the COVID-19 Pandemic. J Addict Med. 2021 Feb 5. doi: 10.1097/ADM.0000000000000809. Epub ahead of print. PMID: 33560696.

Thank you!

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ON OPIOIDS

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