CIAO Time Presents:

Academic Detailing: A case-based approach

The Center for Innovation in Academic Detailing on Opioids

San Francisco Department of Public Health

Agenda

1. Introduction to CIAO
2. Review the basics of academic detailing
3. Detailing Cases with Clinical Content Review
   - ❑ Risks and benefits of starting opioids
   - ❑ Treating opioid use disorder with buprenorphine

** Please ask questions in the **Chat Box** or unmute yourselves and ask live!*

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.

Our Team

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Academic Detailing

Detailing is an **interactive** and **educational** outreach method to engage clinicians around evidence-based information to improve patient care.

Detailing relies on a few simple tenets:

- Provider convenience
- One-on-one interaction
- Digestible information, engaging presentation

Academic Detailing Scenarios:

- Providers can have knowledge gaps
- Providers can be at any stage of change in implementing evidence-based patient care
- Providers have concerns and fears

Clinical Scenarios:

- Patients who aren't on opioids but are living with chronic pain
- Patients who use non-prescribed opioids

Case Study: Risks and Benefits of Starting Opioids

The clinician being detailed is an experienced physician who is resistant to starting patients on opioids if they aren't already taking them.

Clinical scenario in the detailing session:

56 year old cis female with **chronic kidney disease** and **right knee osteoarthritis** for many years.

- Has done *multiple rounds of physical therapy, tried topical lidocaine, corticosteroid injections and Tylenol*.
- The pandemic has made it harder to exercise, she has gained 20 pounds of weight, and is suffering more from her pain and depressed mood.

She has started asking about opioids.

Academic Detailing Mock Session

What to watch for…

Objections: providers may object/resist due to knowledge gaps, burnout, administrative demands, stressors
*these give the detailer opportunity to build rapport and explore provider needs

Steps of a Visit

- Introduction
- Needs Assessment
- Key Messages
- Handling Objections
- Summary/Close Visit
  *behavior change

Academic Detailing Demonstration: Risks and Benefits of Starting Opioids

Case 1: Risks and Benefits of Starting Opioids

What questions would help this provider?

- What types of treatment have you tried for this patient? What else has been successful/failed?
- How does the pain affect the patient's daily life?
- What's the worst that can happen if this patient tries opioids and what's the best possible outcome?

Academic Detailing/Conversation Pearls:

put in the chat!

Common barriers/objections

- My patients keep asking me for opioids.
- My patients always tell me their pain is 10/10.
- We're not supposed to prescribe opioids for chronic pain anymore.
- There are no good data.

Shared decision-making for opioid therapy

Opioids and Chronic Pain Guidebook (page 10)

Avoid making a decision without an individualized conversation with the patient.

1 Ask the patient to describe perceived risks and benefits.

Patients may identify scenarios with limited benefit or increasing risk such as:

- On opioids after pain condition addressed
- No evidence of pain/function improvement
- Very high dose of opioids
- Other risky medications (e.g. benzodiazepines)
- Adverse effects (constipation, overdose, etc.)
- Worsening comorbidities
- Active opioid use disorder

Non-pharmacologic treatment of chronic pain

The Agency for Healthcare Research and Quality conducted a systematic review of noninvasive non-pharmacological treatment for chronic pain and found the following interventions led to significant improvement in function and pain outcomes at least 1 month after completion of treatment:[1]

Knee osteoarthritis:

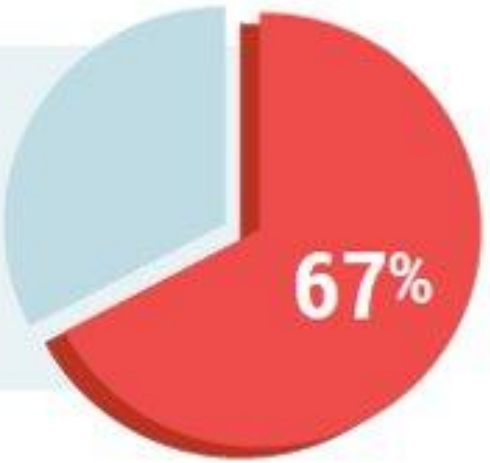
- Exercise
- Ultrasound

Condition	Treatment
Acute, inflammatory pain (e.g., lumbar radiculopathy, bursitis, tendonitis, gout)	• Corticosteroids • NSAIDs
Headaches (e.g., tension-type, migrane)	• Acetaminophen • NSAIDs • Antidepressants (e.g., tricyclics) • Anticonvulsants (e.g., topiramate)
Fibromyalgia	Anticonvulsants (e.g., pregabalin)
Muscle spasm or spasticity	Muscle relaxants (e.g., baclofen)
Neuropathic pain (e.g., peripheral neuropathy)	• Anticonvulsants (e.g., gabapentin, topiramate) • Antidepressants • Topical local anesthetics (e.g., lidocaine)
Osteoarthritis or rheumatoid arthritis	NSAIDs
Chronic musculoskeletal pain (e.g., bone pain)	• Antidepressants (e.g., duloxetine) • NSAIDs

Use a systematic approach to initiating pharmacologic therapy for pain:

1. Record history and physical, pain description, function/social assessment.
2. Determine mechanism of pain.
3. Consider non-pharmacologic options.
4. Consider pharmacologic options that may help.
5. Reassess response at regular intervals and modify treatment accordingly.

Make sure to evaluate risks and benefits—67% of patients prescribed opioids for 90 days are still using opioids at 2 years.[4]



CDC recommends

If opioids *are* appropriate, consider using episodic, short-acting opioids and keep at the lowest effective dose—***low and slow.***

Exercise caution:

- Doses ≥ 50 MME
- Concurrent use of a benzodiazepine, alcohol or methadone for pain

Avoid if possible:

- Dose ≥ 90 MME
- Opioid prescription > 3 months

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Opioids for Chronic Pain Documentation Suggestions

Suggested components of documentation	**Example:** 55 y/o cis-gender male seen for initial provider visit. CC: chronic b/l hand pain.
Pain history Complete OLDCARTS for pain complaint. **TIPS:** Treatment: pain medications, non-pharmacologic therapies, surgeries. Severity: PEG scale includes functional impact of pain. *See "Current pain assessment" below.*	**Onset:** 10 years ago, no specific injury reported **Location:** distal interphalangeal joints of hands and feet **Duration:** 10 years, progressively worse every year **Characterization:** intermittent sharp pains and numbness in hands and feet **Aggravating:** cold and rainy weather **Relieving:** oxycodone (x15 minutes), does not take other meds or do physical therapy **Treatment history:** Oxycodone 30mg 4x/day x10 years. Tapered to 100 tabs last month; does not want opioids anymore, but did not agree to taper & reports more pain. **Severity:** 5-8/10 PEG scale
Other relevant history **Imaging:** x-ray, MRI, ultrasound. **Labs:** related to disease processes or substance related. **Prior notes:** past diagnoses, ROI from other providers. **Other medications:** non-opioid medications.	**Imaging:** 2012: X-ray bilateral hands: erosions **Labs:** 2012: rheumatoid factor mildly elevated **Prior notes:** distal interphalangeal joint swelling consistent with arthritis; missed rheumatology appointment after referral 9 years ago **Other medications:** previously used gabapentin but stopped: "doesn't help pain"
Current pain assessment The 3-question PEG reflects average pain and impact on enjoyment and function over past week (pg. 14)	**Past week average pain:** 5 with medication/ 9 without **Pain interference on life enjoyment:** 6 with medication/ 9 without **Pain impact on general activity:** 4 with medication/ 7 without
Physical exam Complete focused exam yearly or more frequently.	Full range of motion in hands and feet; mild swelling of distal IP joints; sensation intact with sense of numbness in distal and plantar feet.
Risk factor assessment Guides clinical decision-making (pg. 15).	Substance use (ETOH & meth) and psychiatric history (schizophrenia controlled with medication) noted.
Opioid use disorder screening Use DSM-5 (pg. 25).	Patient does not meet the criteria for OUD: 1 criterion noted (unable to stop or cut down).
Urine drug screen (pg. 17)	UDS as expected XX/XX/XXXX and YY/YY/YYYY. Repeat every 3 months given risk profile.
Control substance agreement or consent (pg. 18)	Controlled substance agreement reviewed with patient XX/XX/XXXX. Copy given to patient.
Prescription drug monitoring program (pg. 19)	PDMP reviewed XX/XX/XXXX; no unexpected prescriptions.
Naloxone (pg. 22)	Prescribed intranasal naloxone XX/XX/XXXX. Signs of when to use naloxone reviewed.
Plan Include rational for plan and future goals. **TIPS:** continuity of care, obtainable goals, and minimizing patient risks make a strong rational.	Opioids not indicated for neuropathic pain and patient has some risks. However, for now will continue current dose of oxycodone b/c patient has done well for years, underwent challenging recent taper, has no evidence of OUD, and is new to me. Given risks associated with discontinuation, will work closely with patient to reduce reliance on opioids. Repeat hand X-rays ordered. Follow UDS every 3 months and continue screening for OUD.

*Page numbers refer to **Opioids and Chronic Pain: A Guide for Primary Care Providers**, available at www.ciaosf.org/materials

Takeaways

- Opioids are an option when other therapies have been trialed and unsuccessful.
- Just because patients want to try an opioid doesn't mean they are trying to manipulate. Consider the patient as a human being and attempt shared decision-making.
- There are ways to trial opioids for patients with chronic pain that are safe, time-limited, and evidence-based.

Case Study:

The clinician being detailed is a newly licensed Nurse Practitioner who is very interested in obtaining an X-waiver and offering Buprenorphine treatment for OUD, but she is not sure how to integrate it into her primary care practice.

Clinical scenario in the detailing session:

Pt is a 25yo cisgender man who disclosed a **hx of prescription opioid use** starting in high school. He started **smoking heroin about 2 years ago**. He does not have stable housing, nor reliable transportation.

He has a friend who recently started Buprenorphine and is interested in trying it himself

Academic Detailing Mock Session

What to watch for…

Objections: providers may object/resist due to knowledge gaps, burnout, administrative demands, stressors
*these give the detailer opportunity to build rapport and explore provider needs

Steps of a Visit

- Introduction
- Needs Assessment
- Key Messages/Benefits
- Handling Objections
- Summary/Close Visit

Academic Detailing Demonstration: Initiating Buprenorphine Treatment

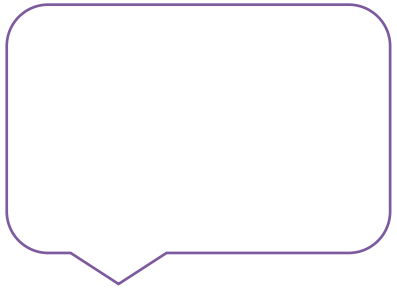
Case 2: Initiating Buprenorphine Treatment

What questions would help this provider?

- How comfortable are you with providing telehealth services?
- What do you know about the updated X-waiver process?
- What do you know about prescribing Buprenorphine to polysubstance users?
- How do you know if Buprenorphine treatment is appropriate for this patient?
- How would you start this patient on Buprenorphine?

Academic Detailing/Conversation Pearls:

put in the chat!



Common barriers/objections

- I do not have my X-waiver yet
- I am concerned that marginally housed patients will not be able make their in-person appointments
- I am not sure how to handle patients who are polysubstance users
- My clinic does not offer substance use counseling

Obtaining the waiver to prescribe buprenorphine for OUD

- The buprenorphine or X waiver is required for providers to prescribe buprenorphine for OUD. Prescribing buprenorphine ONLY for pain does NOT require an X waiver, but may require prior authorization.
- Any MD, DO, NP, CNS, CRNA, or CNM with a state license and DEA number can obtain an X waiver by submitting a Notice of Intent online.
  - Additional training is *no longer required* to prescribe buprenorphine to ≤30 patients at a time for OUD.
  - To prescribe buprenorphine to >30 patients, training is required (8 hours for MD or DO, 24 hours for others) and providers must meet SUPPORT Act criteria (i.e. work in qualified practice setting or are boarded in addiction medicine)

1. **Complete and submit online form: bit.ly/X-waiver_application**
2. **Receive waiver approval via email or letter from SAMHSA within 45 days.**
3. **Receive DEA X waiver identification number 7 to 10 business days following waiver approval.**

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

Does telehealth work for buprenorphine?

Before COVID-19:

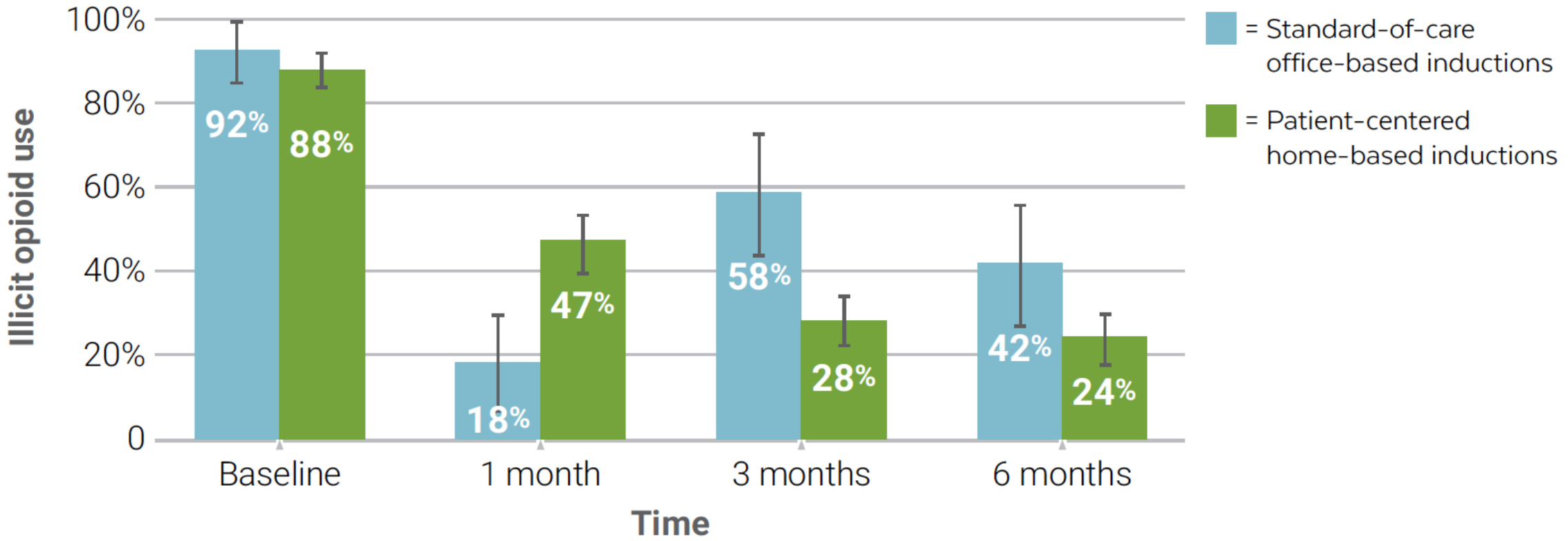
- A non-randomized study in the VA showed that buprenorphine initiation via telehealth can be **conducted safely** and potentially **increase access** to buprenorphine in rural communities *(Brunet et al, 2019)*

During COVID-19:

- A telemedicine buprenorphine clinic in New York City started 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)*

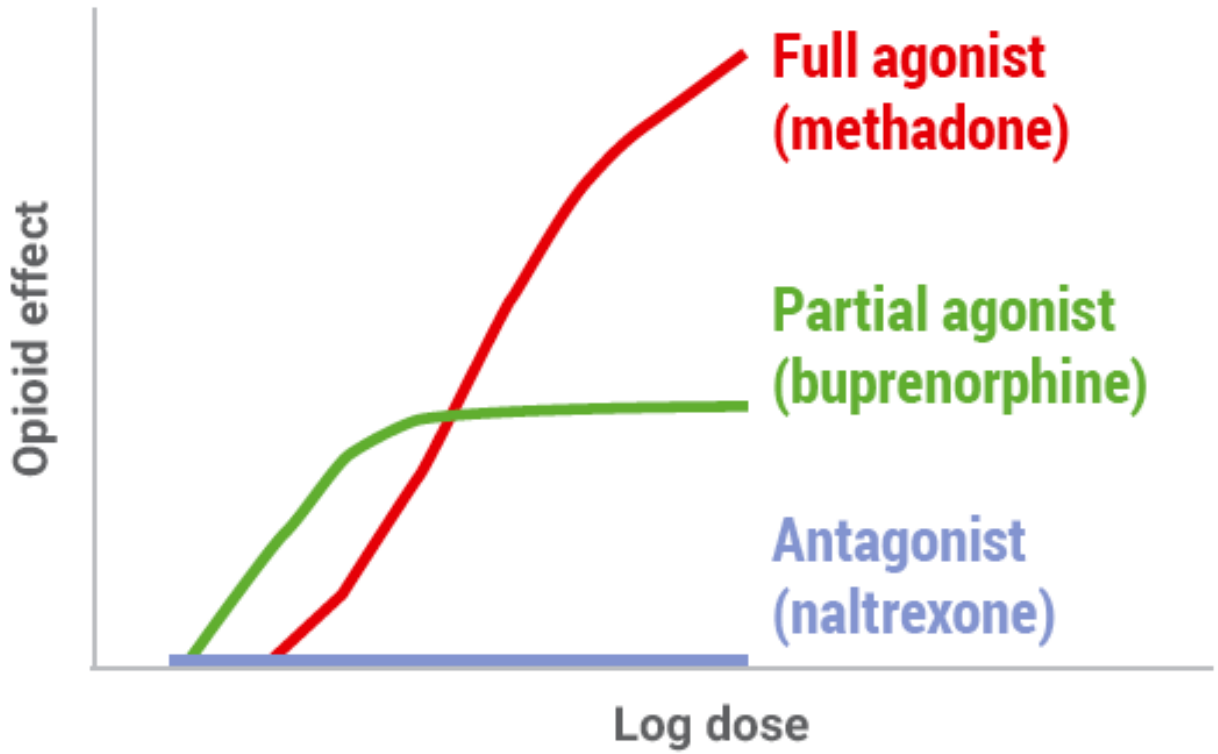
PATIENTS CAN BE STARTED ON BUPRENORPHINE IN THE OFFICE *OR* AT HOME

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



Cunningham et at, 2011

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

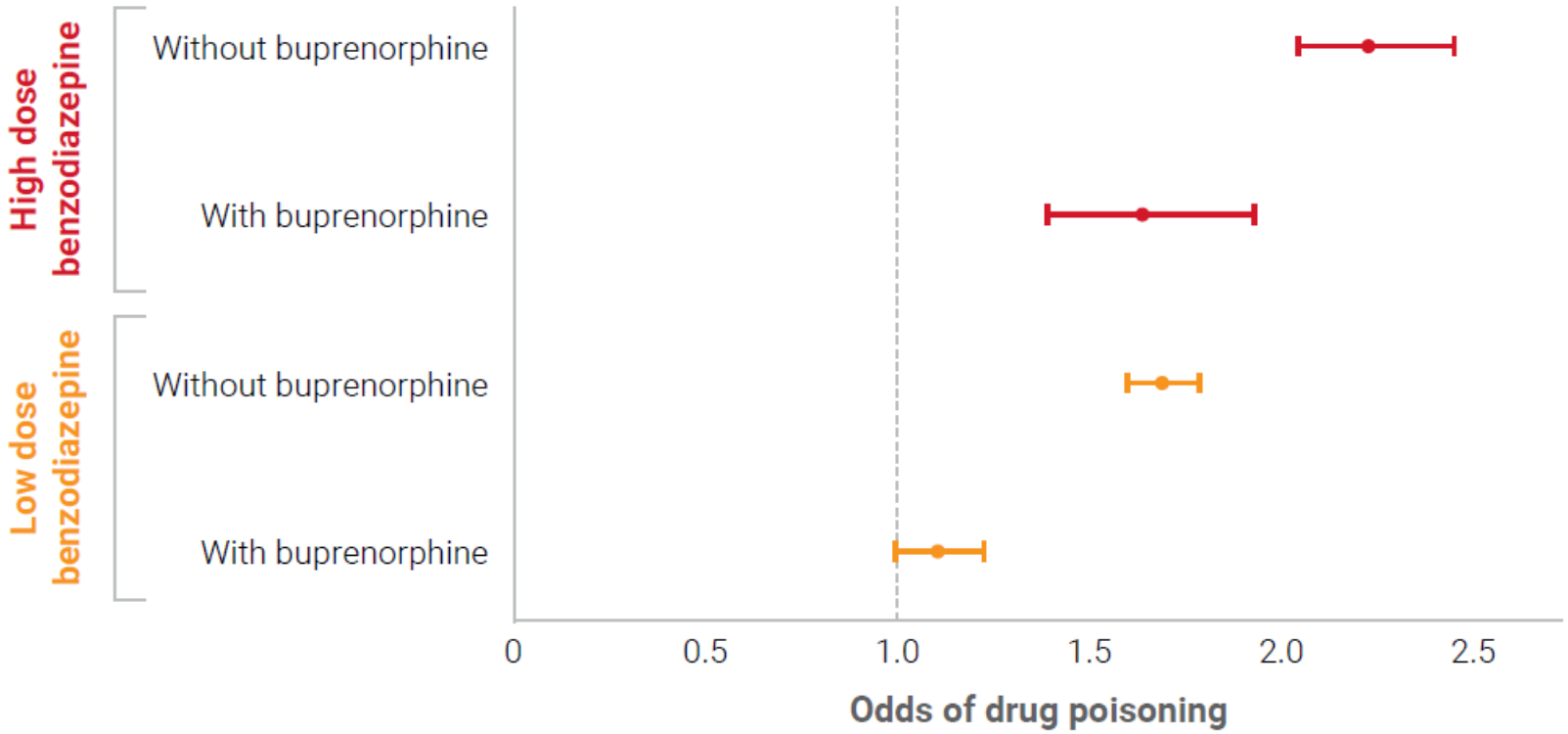
- Due to the "ceiling effect" of a partial agonist, buprenorphine has:
  - **Low potential for misuse** and diversion
  - **Low risk** of respiratory depression or overdose
  - **Ability to reduce craving and withdrawal** without the euphoria of full agonist
- Maintenance is critical: OUD requires long-term 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.

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.

BUPRENORPHINE IMPROVES SAFETY FOR PATIENTS WITH OUD PRESCRIBED BENZODIAZEPINES[14]



The odds of drug poisoning is lower if buprenorphine is added to benzodiazepines.

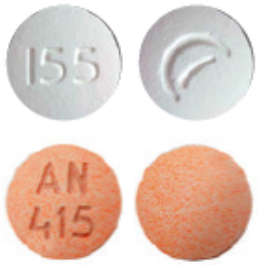
Xu KY, Borodovsky JT, Presnall N, Mintz CM, Hartz SM, Bierut LJ, Grucza RA. Association Between Benzodiazepine or Z-Drug Prescriptions and Drug-Related Poisonings Among Patients Receiving Buprenorphine Maintenance: A Case-Crossover Analysis. Am J Psychiatry. 2021 Jul;178(7):651-659. doi: 10.1176/appi.ajp.2020.20081174. Epub 2021 Mar 3. PMID: 33653119; PMCID: PMC8286284.

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

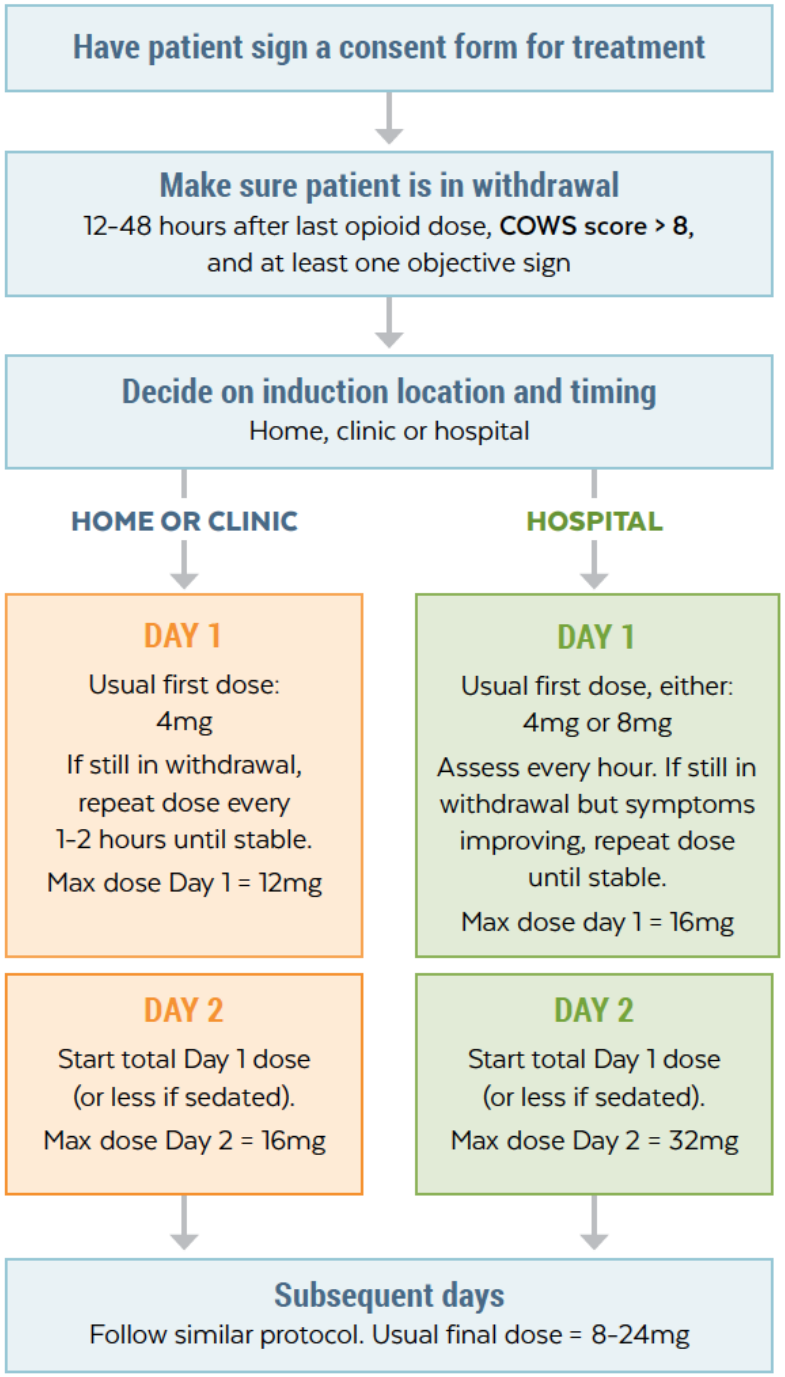
MONOFORMULATED BUPRENORPHINE

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

Buprenorphine overlap initiation

Extremely high tolerance to opioids increases the risk of **precipitated withdrawal.**
An alternative is buprenorphine overlap initiation which avoids this risk.

CONSIDER WHEN PATIENT:

- Doesn't want to experience withdrawal
- Had prior difficulty starting buprenorphine
- Uses fentanyl
- Wants to switch from methadone

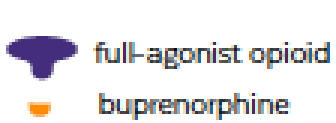
AVOID WHEN PATIENT:

✗ Prefers a rapid start or is already in significant withdrawal

✗ Is unable to take buprenorphine multiple times a day

TRADITIONAL VS. OVERLAP INITIATION OF BUPRENORPHINE:

Patient taking full-agonist opioids (e.g., methadone, fentanyl)



Option 1
Traditional initiation
- Guaranteed withdrawal
- Risk of precipitated withdrawal

Opioids stopped.
Patient experiences withdrawal.

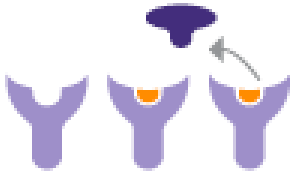
Option 2[31]
Overlap initiation
- Very low risk of withdrawal[32]

Buprenorphine and full agonist opioids taken at the same time.

DAY 1

Possible outcomes:

Buprenorphine replaces full agonist opioids.



Patient may go through precipitated withdrawal (high risk with methadone and fentanyl).

DAY 2

Buprenorphine gradually replaces full agonist opioids without withdrawal.

DAY 3+:
Buprenorphine dose increased and patient stabilized.

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.**

Takeaways

- Telehealth can be used to **start and continue patients** on buprenorphine.
- Patients should not be refused buprenorphine because they use other substances.
  - ***Buprenorphine is safer than any street opioids / full agonists***
- New buprenorphine initiation strategies limit withdrawal.

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Substance Use Warmline

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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

Thank you!

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CENTER FOR INNOVATION
IN ACADEMIC DETAILING
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