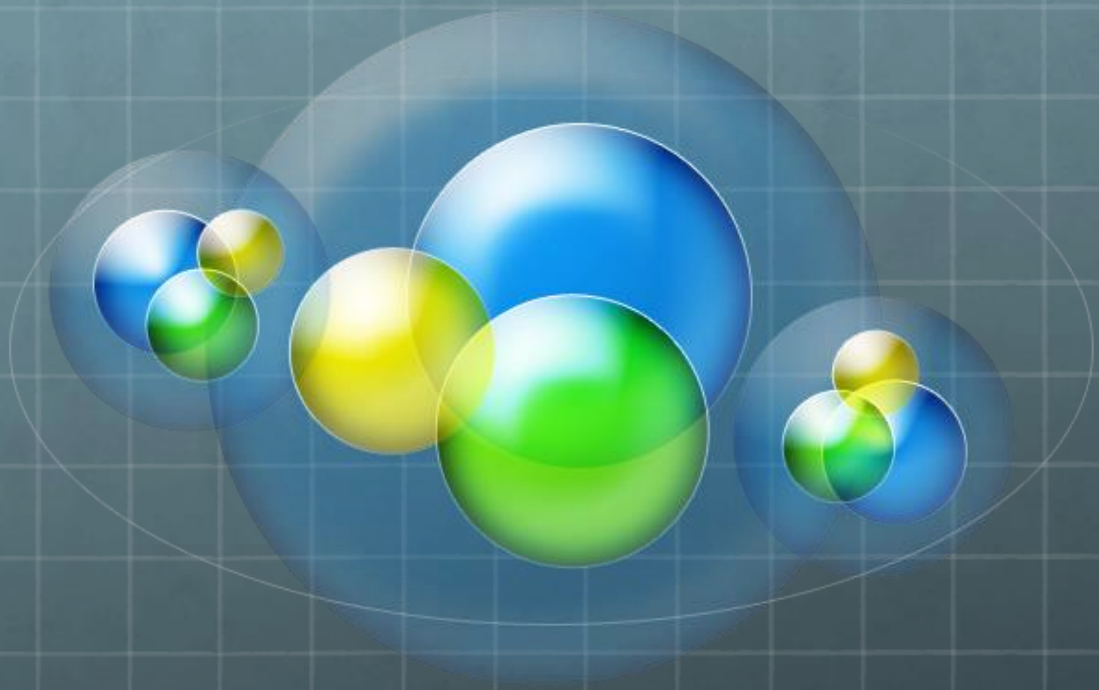


The Opioid Crisis

What you can do as a family physician?

Ramm Hering MD CCFP DipABAM
Anne Nguyen MD CCFP

Introduction (Ramm)

Current

- Addiction Medicine Physician
  - Pandora Clinic
  - Island Health
    - Rapid Access Addiction Clinic (RAAC)
    - Addiction Outpatient Treatment (AOT) Clinic
- Psychiatry Hospitalist at Royal Jubilee Hospital

Past

- Clinical Fellowship Addiction Medicine
  - 1 year, University of Toronto, 2014
- Family Physician 2009-2014, Halifax NS
  - full service family medicine + opioid addiction care

Introduction (Anne)

- Family Physician at Cool Aid Community Health Services since 2015
- Hospitalist at Royal Jubilee Hospital since 2015
- 2011-2015 Family Physician in Sioux Lookout, ON
  - Opioid crisis in northern Ontario communities
  - “Community Suboxone Programs” a creative response to the crisis conditions
  - Bup/Nlx prescribed by almost every GP in the region

Sioux Lookout, ON

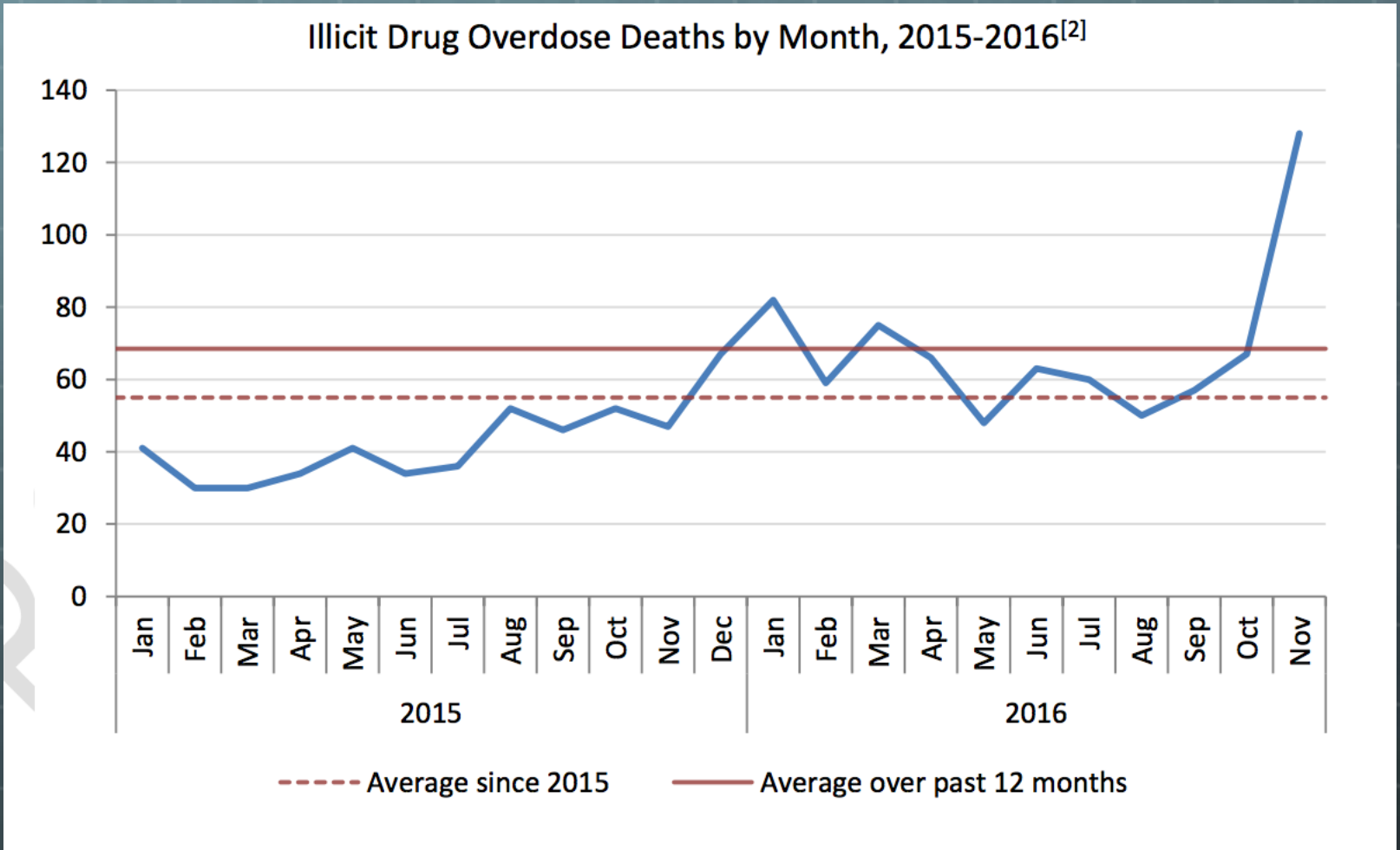
Disclosures/Conflicts of Interest

- Sessional payment from VDFP
- No pharma company or other funding (although we will be talking a lot about buprenorphine)

Overview

- Provide context to the current opioid crisis
- Review key addiction points
- Guideline for the Clinical Management of Opioid Use Disorder
- What role could family physicians play?
- Buprenorphine (Suboxone) as the first line treatment for OUD
- Resources for patients and family physicians
- Next Steps for the South Island community in the opioid crisis

Overdose Deaths in BC



Source: Illicit Drug Overdose Deaths in BC, January 1, 2007 to November 30, 2016. Office of the Chief Coroner of BC..

Overdoses and Deaths in South Island

Past Week in the South Island

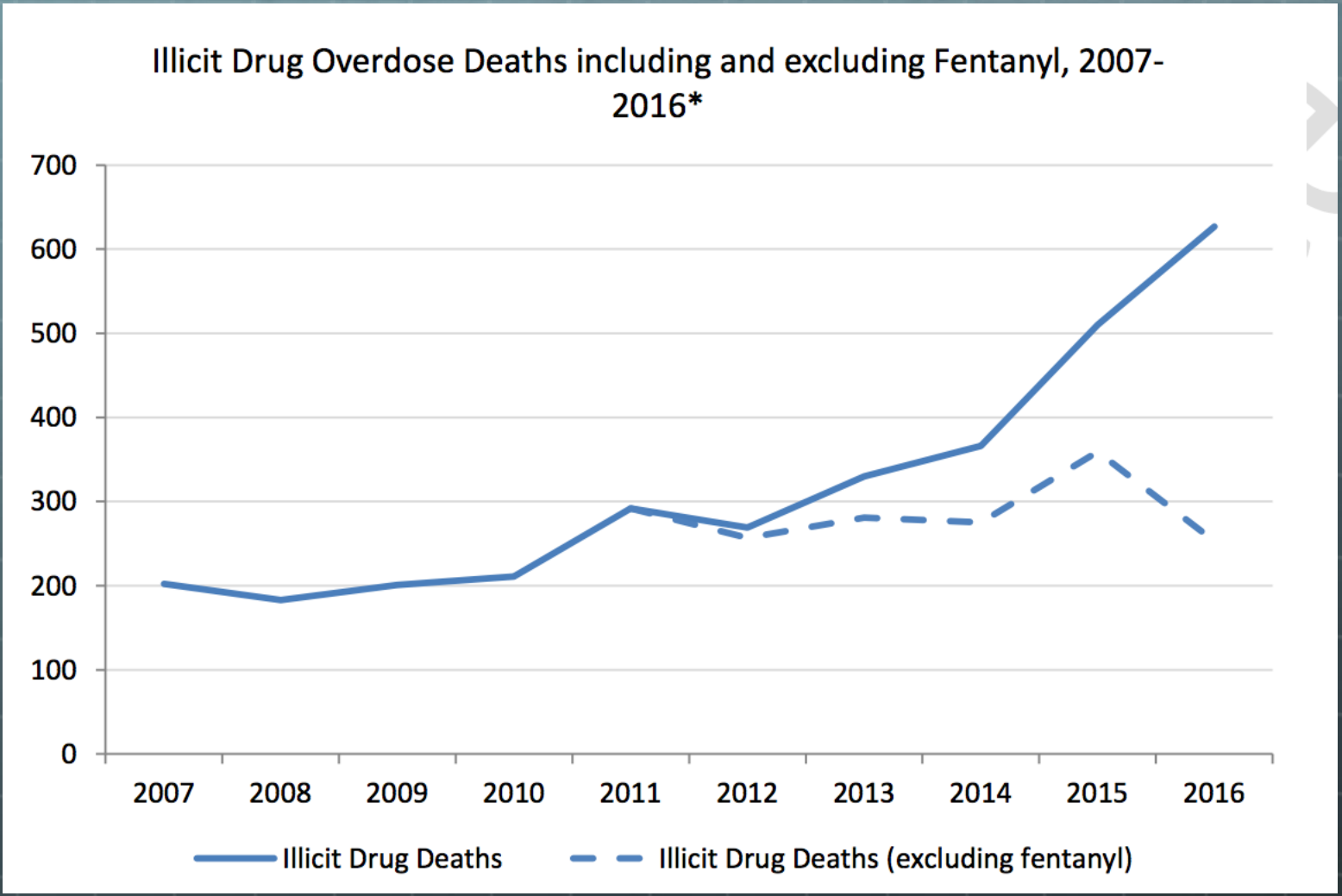
- 24 ER visits for Overdose
- 78 Ambulance Calls for Overdose

O/D Deaths in South Island (All of BC)

- 2014 =23 (366)
- 2015=23 (513)
- 2016=75 (922)
- Jan 2017=7 (116) => on track for close to 100 deaths in South Island and 1400 in the province in 2017

Island Health Mortality

- Mortality is 19.7/100,000 from opioid O/D
- 143% increase from 2015 to 2016, 2nd highest increase in province



Source: Illicit Drug Overdose Deaths in BC, January 1, 2007 to November 30, 2016. Office of the Chief Coroner of BC.


Leading the way in HIV prevention
and addiction services
BRITISH
COLUMBIA

How did we get here?

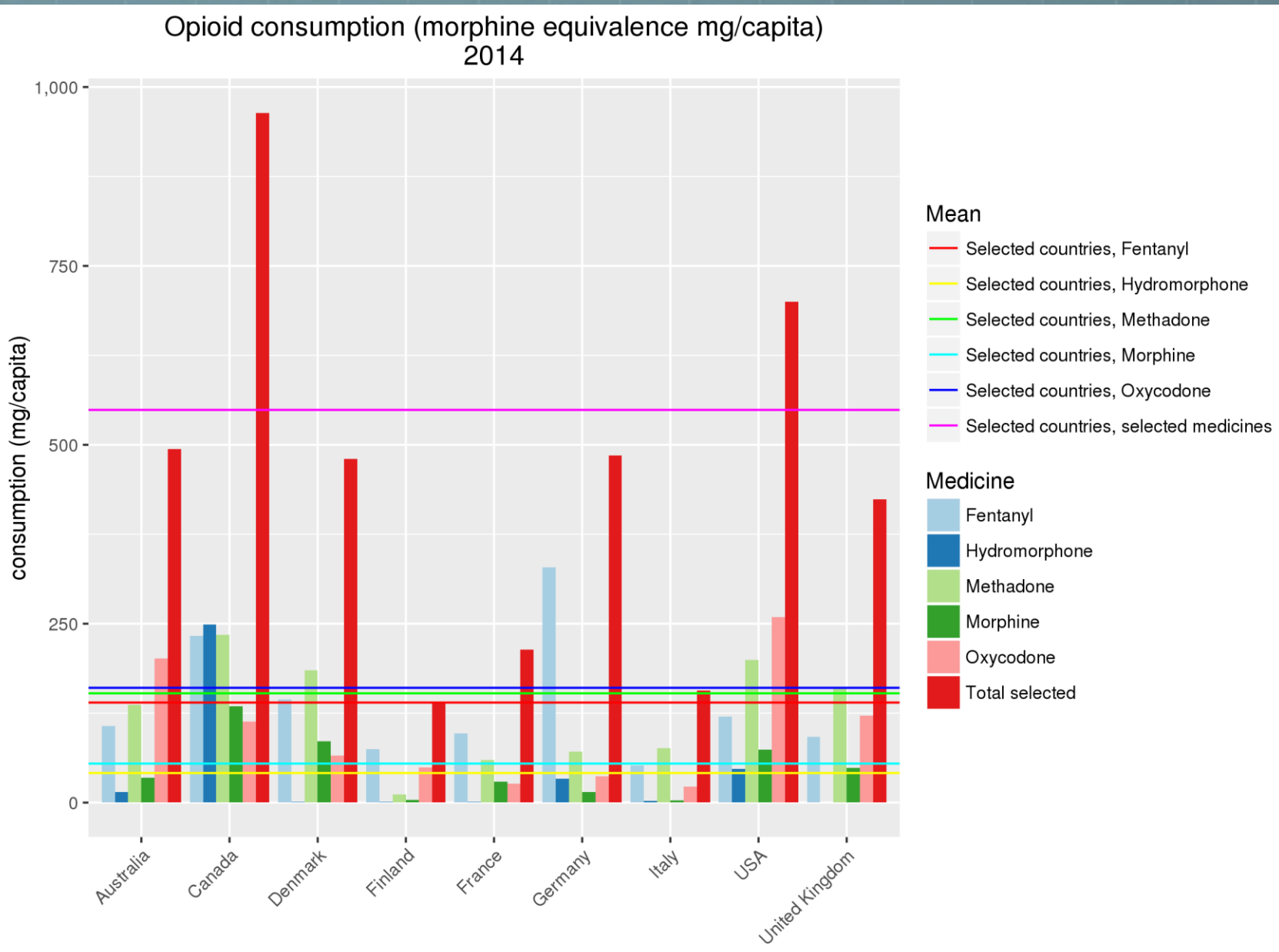
1. Too Much Potent Opioid Consumed

- Too many opioid prescriptions
  - Overestimating opioid benefits for chronic non-cancer pain and underestimating harms
  - Aggressive marketing from pharmaceutical companies based on short term data
  - Lack of physician education around safe opioid prescribing
- Illicit Opioids have become much more potent (fentanyl/carfentanil) and probably cheaper
  - opioid addiction is old but volume of deaths is new
    - More people exposed to more potent opioids

How did we get here?

2. Lack of access to evidence-based treatment for opioid use disorder

- Little education about addictions in medical school/residency
- Lack of knowledge around opioid addiction identification
- Lack of knowledge around best treatment for OUD
- Lack of access to prescribers of Opioid Agonist Therapy (OAT)
  - Regulatory environment not encouraging of docs to prescribe OAT especially by PCPs
    - Difficulty of getting methadone exemption
    - Buprenorphine prescribing was tied to having a methadone exemption



Sources: International Narcotics Control Board; World Health Organization population data

By: Pain & Policy Studies Group, University of Wisconsin/WHO Collaborating Center, 2017

3 Key Messages about Addiction

Goals

1. Addiction is a **Chronic Brain Disease**
2. There is **Good Treatment** for Addiction
3. **All of Society Benefits** when Addiction is well treated

American Association for the Treatment of Opioid Dependence-(AATOD)

Addiction as a BRAIN Disease

Nora Volkow

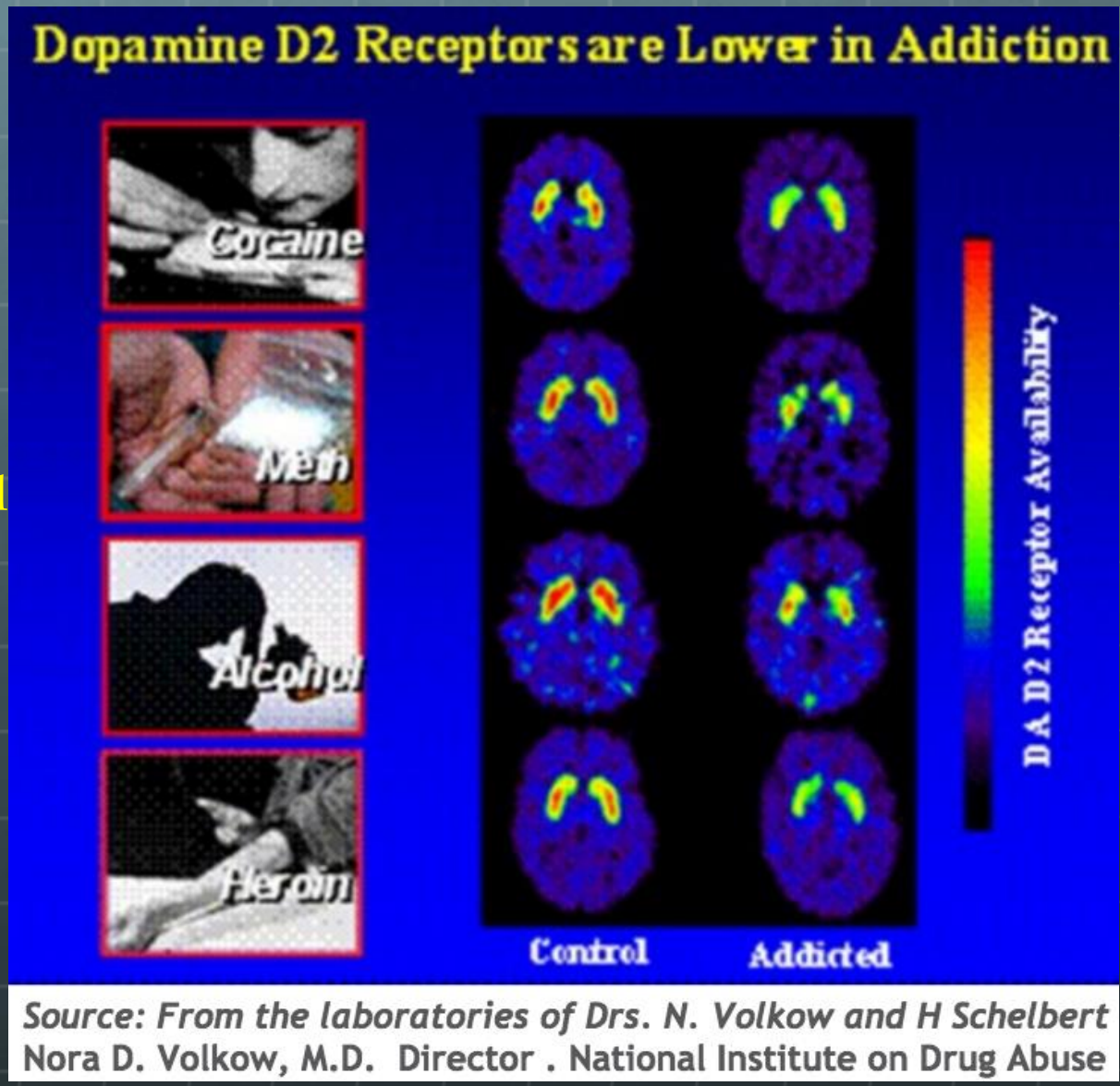
- Addiction Psychiatrist

- Director of NIDA (NIH)
- fMRI + PET

Neuroanatomical + Functional Brain Changes

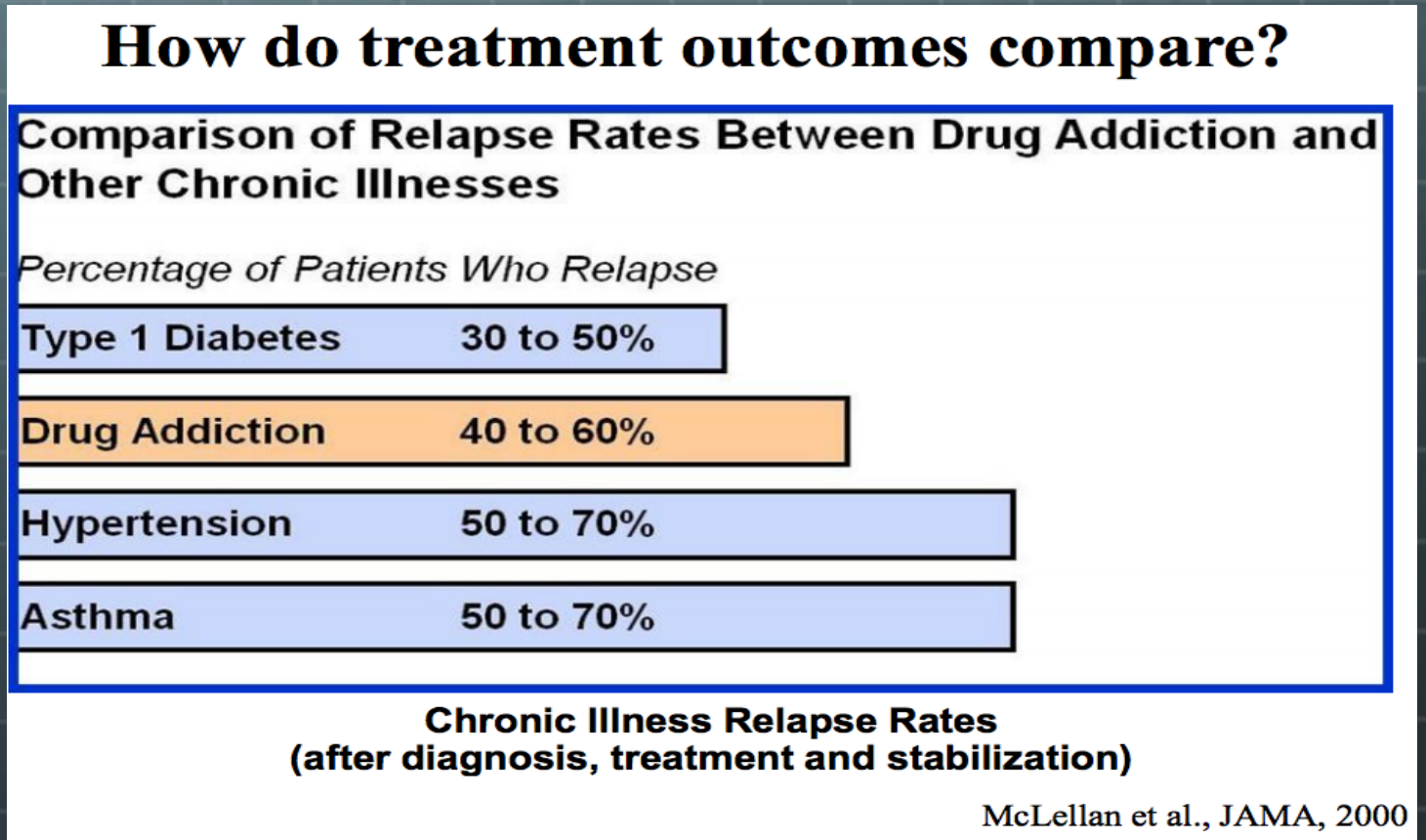
1. Result of drug use
2. Lead to further drug use

Starting to use Drugs is a choice
Addiction is **NOT** a choice



Addiction as a CHRONIC Brain Disease

- Like other chronic diseases Addiction is Relapsing and Remitting
- Goal, with good treatment, is actually Remission (Not Cure)
- But relapses do sometimes occur

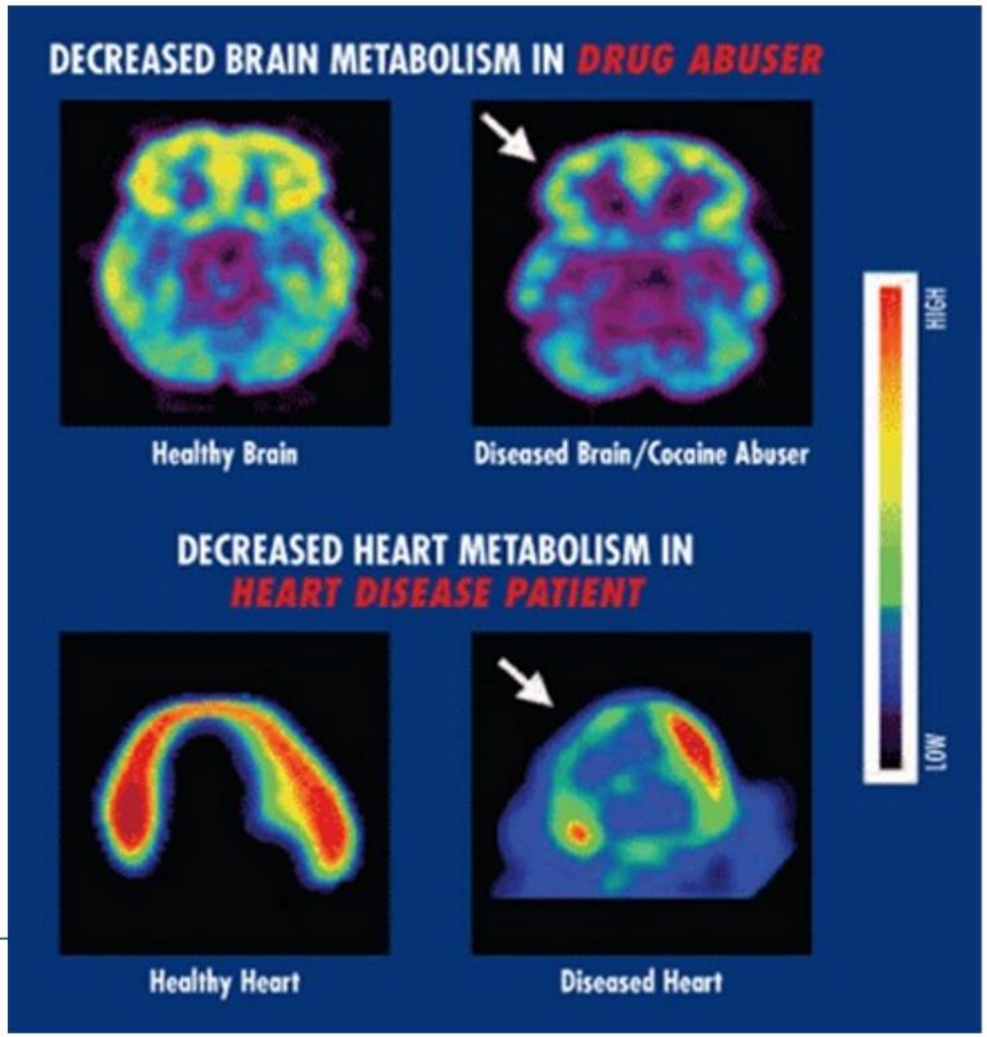


Like other Chronic Diseases there is

End Organ Damage…

In Addiction the End Organ is the…

BRAIN



Source: From the laboratories of Drs. N. Volkow and H Schelbert
Nora D. Volkow, M.D. Director . National Institute on Drug Abuse

DSM 5 – Opioid Use Disorder

Addiction vs. Physical Dependence

Impaired Control

1. Taken in larger amounts for longer periods than intended
2. Persistent desire or repeated unsuccessful efforts to stop
3. Preoccupation with drug great deal of time obtaining, using, and recovering
4. Craving/Strong Desire/Urge

Social Impairment

6. Persistent/recurrent social/interpersonal problems
7. ↓ in important social, work, or recreational activities

Risky Use

8. Recurrent use when physically hazardous
9. Continued use despite causing physical/psych problem

2 or more in a 12 month period

2-3=mild
4-5=Moderate
6 or more=Severe

Pharmacologic

10. Tolerance
    - need ↑ dose for desired effect (in opiates, tolerance to analgesic effects develops slowly, tolerance to psychoactive effect develops rapidly)
    - ↓ effect with constant dose
11. Characteristic withdrawal syndrome, (or use to avoid)

Physical Dependence is a big part of OUD

A case really close to home

"Want help can't get it"

- 46 y.o. M works in service industry, owns own home
- Alcoholism since early 20's, abstinent x 15 years
- Then got into cocaine, now in remission
- 5 years ago got into opioids recreationally and developed daily heroin habit
- Went to Victoria Detox and got on Buprenorphine

Case continued

- Self tapered off Buprenorphine and maintained abstinence x 1 year
  - Reports that his friends in recovery look down on OAT as a crutch
- In last year, intermittent relapses which he has disclosed to his GP and has asked for help
- GP informs “I’m not comfortable prescribing Suboxone”
- Dx “Heroin addiction” documented in chart, multiple times
- Plan: “Refer to detox”
- The patient is still working and doesn’t see how going to detox can fit into his life but is desperate to break the cycle of use and withdrawal

So he goes to ER to ask for help…

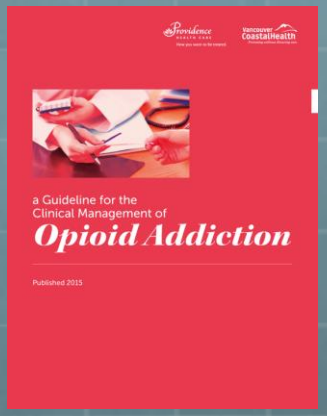
- Knows a few things about getting started on Buprenorphine – like he needs to be in withdrawal (more on this later – so presents to local ER 36 hours after last dose of heroin in florid withdrawal hoping to get started on Buprenorphine
- Told in his local ER no docs prescribe Buprenorphine
- Advised to do intake for Detox

TOO MANY WRONG DOORS!

As family physicians we can choose to be the "right door"

- In the age of fentanyl in the drug supply, being told "I can't help you" or "Go to detox" (for which the wait can be weeks) can be lethal
- Being abruptly discontinued from opioids turns many patients to the streets
- We can equip ourselves with the tools to help these patients… by
  1) Diagnosing OUD AND
  2) Prescribing Buprenorphine ourselves OR
  3) Rapidly refer for treatment (Bup or methadone) and then continuing/monitoring patients who have been started
  4) Overdose prevention through Take Home Naloxone (THN) education


Overdose
Death
HIV
Infections
Crime
Family
Jobs
Legal
Hospital
Mental Illness
Science
Inpatient/Outpatient Detox
Withdrawal/Taper
Psychosocial Treatment
OAT
Methadone
Buprenorphine/Naloxone
Mandatory Counselling?
Tapers vs. Maintenance
Opiate Addiction



Clinical Review & Education

JAMA Clinical Guidelines Synopsis

Clinical Management of Opioid Use Disorder

Beth Dunlap, MD; Adam S. Cifu, MD

GUIDELINE TITLE Guideline for the Clinical Management of Opioid Addiction

DEVELOPER Vancouver Coastal Health, Providence Health Care, and Ministry of Health, British Columbia, Canada

RELEASE DATE November 2015

FUNDING SOURCE Funded publicly through governmental grants

TARGET POPULATION Nonpregnant adult patients with opioid use disorder

MAJOR RECOMMENDATIONS

- Opioid withdrawal alone is not recommended for treatment of opioid use disorder in most patients because of increased risks of overdose death and infectious disease, particularly HIV through intravenous drug use, following detoxification (moderate-quality evidence, strong recommendation).
- In the absence of contraindications, medically supervised opioid agonist treatment should be offered to patients. Buprenorphine/naloxone is the preferred first-line treatment. Methadone is an alternative in certain patient populations (high-quality evidence, strong recommendation).
- Psychosocial supports tailored to patient needs may be offered as an adjunct to medical treatment (moderate-quality evidence, conditional recommendation).

Summary of the Clinical Problem

Death caused by drug overdose is a major problem in the United States. In 2014, nearly 29 000 people died of opiate overdose.[1] Underlying this trend is a parallel increase in opioid use disorder, defined as a problematic pattern of opioid use leading to clinically significant impairment or distress. Opioid use disorder contributes to significant mortality, primarily from overdose, as well as morbidity.

Related article page 282

Guidelines for treatment of patients addicted to opiates potentially can improve both patient and public health outcomes. Of the estimated 2.5 million people in the United States with opioid addiction,[2] fewer than half are able to access medication-assisted treatment (MAT). 53.4% of US counties do not have a single prescriber of medications to treat opioid use disorder, and, as of 2014, only 2.2% of US physicians had obtained the necessary waiver to prescribe buprenorphine.[3] MAT is an

Evidence Base

A systematic literature review was the basis of the guideline.[4] Evidence was summarized using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) criteria. Strong recommendations were given to use of agonist therapy as first-line treatment on the basis of 7 Cochrane reviews published between 2003 and 2014 with high- to moderate-quality evidence. Study heterogeneity and limited outcome information precluded supporting a single approach to psychosocial interventions and support structures. There have been no meta-analyses of residential treatment programs, many of which provide intensive behavioral therapy along with withdrawal or agonist management while removing the patient from prior environmental triggers for opioid use.

Benefits and Harms

MAT is superior to withdrawal alone. Multiple studies of withdrawal

Release date:
Feb 7, 2017

A Guideline for the Clinical Management of Opioid Use Disorder

BRITISH COLUMBIA | Ministry of Health

BRITISH COLUMBIA CENTRE ON SUBSTANCE USE

Expert guideline – summary of recommendations

Summary of Recommendations

Recommendation	Quality of evidence*	Strength of recommendation*	Refer to Evidence Summary (pp.)
Approaches to avoid			
1. Withdrawal management alone (i.e., detoxification without immediate transition to long-term addiction treatment†) is not recommended, since this approach has been associated with elevated rates of relapse, HIV infection and overdose death. This includes rapid (< 1 week) inpatient tapers with methadone or buprenorphine/naloxone.	⊕⊕⊕ Moderate	Strong	17-20
Possible first-line treatment options			
2. Initiate opioid agonist treatment with buprenorphine/naloxone whenever feasible to reduce toxicities and facilitate recovery through safer take-home dosing.	⊕⊕⊕⊕ High	Strong	23-25, Table 2
3. Initiate opioid agonist treatment with methadone when treatment with buprenorphine/naloxone is not preferable (e.g., challenging induction).	⊕⊕⊕⊕ High	Strong	21-25, Table 2
4. If withdrawal management is pursued, for most patients, this can be provided more safely in an outpatient rather than inpatient setting. During withdrawal management, patients should be immediately transitioned to long-term addiction treatment† to assist in preventing relapse and associated harms. See also #9.	⊕⊕⊕ Moderate	Strong	17-20
Adjunct or alternative treatment options			
5. For individuals responding poorly to buprenorphine/naloxone, consider transition to methadone.	⊕⊕⊕⊕ High	Strong	23-25, Table 2
6. For individuals responding poorly to methadone, or with successful and sustained response to methadone desiring treatment simplification, consider transition to buprenorphine/naloxone.	⊕⊕⊕ Moderate	Strong	23-25, Table 2
7. For individuals with a successful and sustained response to agonist treatment desiring medication cessation, consider slow taper (e.g., 12 months). Transition to oral naltrexone could be considered upon cessation of opioids.	⊕⊕⊕ Moderate	Strong	29-31
8. Psychosocial treatment interventions and supports should be routinely offered in conjunction with pharmacological treatment.	⊕⊕⊕ Moderate	Strong	20-21

Treatment options for OUD

- Inpatient Medical Detox for rapid opioid withdrawal
  - More harmful than no treatment……Abrupt loss of tolerance:
    - increased O/D risk
    - increased HIV and HCV seroconversion
- Slower outpatient opioid withdrawal
  - Less dangerous….depends, but not good evidence for effectiveness
- Psychotherapeutic treatments
  - various intensities and various treatment settings… mixed results
- Residential Treatment
  - No systematic reviews or meta-analyses
  - Relapse (Smyth et al., 2010) rates are very high
  - No OAT 2 times risk of death (Matthias Pierce 2016)
  - Generally disappointing given cost and wait time

The silver lining…

- Opioid Agonist Treatment (OAT) with Buprenorphine is the first line treatment and is available to Family Docs to prescribe.
- Family Docs are the most well placed clinicians to manage OUD
- OUD is managed as well by Family Docs as by specialists… and patients are happier!

ANNALS OF FAMILY MEDICINE

Treating Opioid Addiction With Buprenorphine-Naloxone in Community-Based Primary Care Settings

Ira L. Mintzer, MD[1]
Mark Eisenberg, MD[2]
Maria Terra, BA[1]
Casey MacVane, MD, MPH[2]
David U. Himmelstein, MD[1]
Steffie Woolhandler, MD[1]

[1]Harvard Medical School/Cambridge Health Alliance, Cambridge, Mass

[2]MGH-Charlestown HealthCare Center/ Harvard Medical School, Boston, Mass

ABSTRACT

PURPOSE Office-based treatment of opioid addiction with a combination of buprenorphine and naloxone was approved in 2002. Efficacy of this treatment in nonresearch clinical settings has not been studied. We examined the efficacy and practicality of buprenorphine-naloxone treatment in primary care settings.

METHODS We studied a cohort of 99 consecutive patients enrolled in buprenorphine-naloxone treatment for opioid dependence at 2 urban primary care practices: a hospital-based primary care clinic, and a primary care practice in a free-standing neighborhood health center. The primary outcome measure was sobriety at 6 months as judged by the treating physician based on periodic urine drug tests, as well as frequent physical examinations and questioning of the patients about substance use.

RESULTS Fifty-four percent of patients were sober at 6 months. There was no significant correlation between sobriety and site of care, drug of choice, neighbor-

CONCLUSIONS Opioid-addicted patients can be safely and effectively treated in nonresearch primary care settings with limited on-site resources. Our findings suggest that greater numbers of patients should have access to buprenorphine-naloxone treatment in nonspecialized settings.

suggest that greater numbers of patients should have access to buprenorphine-naloxone treatment in nonspecialized settings.

Recent Progress

1. Changes in Regulatory Environment

- No longer need to have a methadone exemption to prescribe Buprenorphine (July 2016)
  - CPSBC methadone 101 Course being replaced by BCCSU online courses to prescribe either methadone or buprenorphine

2. Changes in Access to Funding for Treatment

- Plan G Coverage for Buprenorphine

3. Launch of British Columbia Center on Substance Use (BCCSU)

- Guideline for the Clinical Management of Opioid Use Disorder
  - Better ability to practice according to evidence
- Mandate For Physician Education and Support

4. Opening of Overdose Prevention sites

- 3 in Victoria

Recent Progress

5. More clinical support for addiction treatment

- Provincial Addiction RACE (Rapid Access to Consultative Expertise) Line
  - Toll Free: 1-877-696-2131 via App raceconnect.ca/race-app

6. Rapid Referral Options

- Rapid Access Addiction Clinic (RAAC) @1119 Pembrooke Street
  - Just opened Feb 17, 2017
  - Monday and Friday mornings
  - Short term treatment 2 weeks to 2 months
  - Rapid Assessment and Initiation on OUD
  - Needs to be able to transfer patients OUT once on stable dose out.
- Pandora, Cool-AID, Outreach Services Clinic

7. Coming Soon

- New Primary Care Substance Use Physician Lead position with Island Health
  - More support for Primary Care Physicians treated OUD
  - Development of Coordination of Network of Primary Care Buprenorphine prescribers
- In Hospital Addiction Medicine Consult Service

In summary…

- Family doctors are (a big) part of the solution to the opioid crisis
- Buprenorphine is first line treatment for OUD in the new guidelines due to efficacy and safety
- Any physician can prescribe Buprenorphine (without a methadone exemption)
- **Education:**
  - **CPSBC guidelines (prior to June 5th):** it is "strongly recommended" you do a 3-hour online CME course (suboxonecme.ca) and print the certificate
  - **BCCSU Guidelines (after June 5th):** no training required, good to get education (at an event like this or the May 27th Suboxone prescribing event)

The Magic of Buprenorphine/Nlx

1) Synthetic opioid receptor partial-agonist
   - Relieves opioid withdrawal
   - Minimal respiratory depression
2) Very high affinity for opioid receptor
   - Blocks heroin and other opioids
3) Long $T_{1/2}$, ~37h (variable up to 60 hrs)
   - Only need to use once/day to avoid withdrawal
4) Sublingual Consumption
   - Only Bup, not nlx absorbed
   - Nlx is deterrent to IV abuse

Opioid Agonist Treatment works…

- ↓ illicit opioid use
- ↓ IVDU and needle sharing
- ↓ multiple sex partners or exchange of sex for drugs or money
- ↓ HIV Seroconversion
- ↓ criminal behaviour
- ↓ mortality
- ↑ physical and mental health
- ↑ employment
- ↑ social functioning
- ↑ quality of life

*Gowing et al. 2011, Cochrane Review and many others

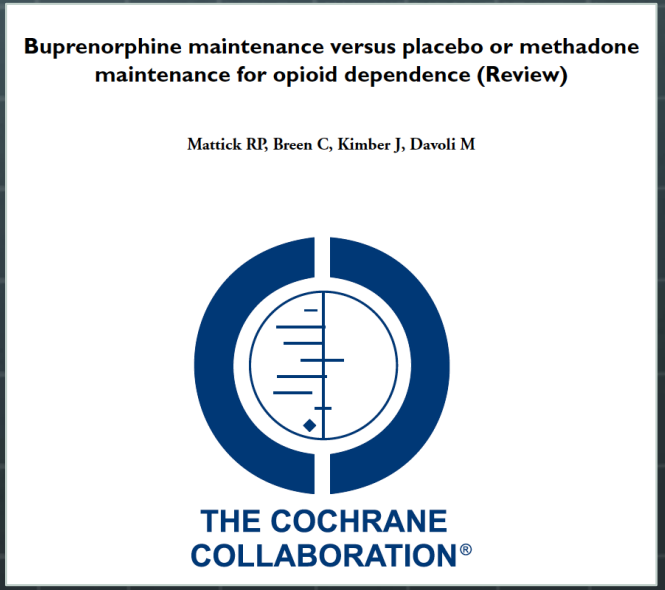
Does Buprenorphine work?

YES!

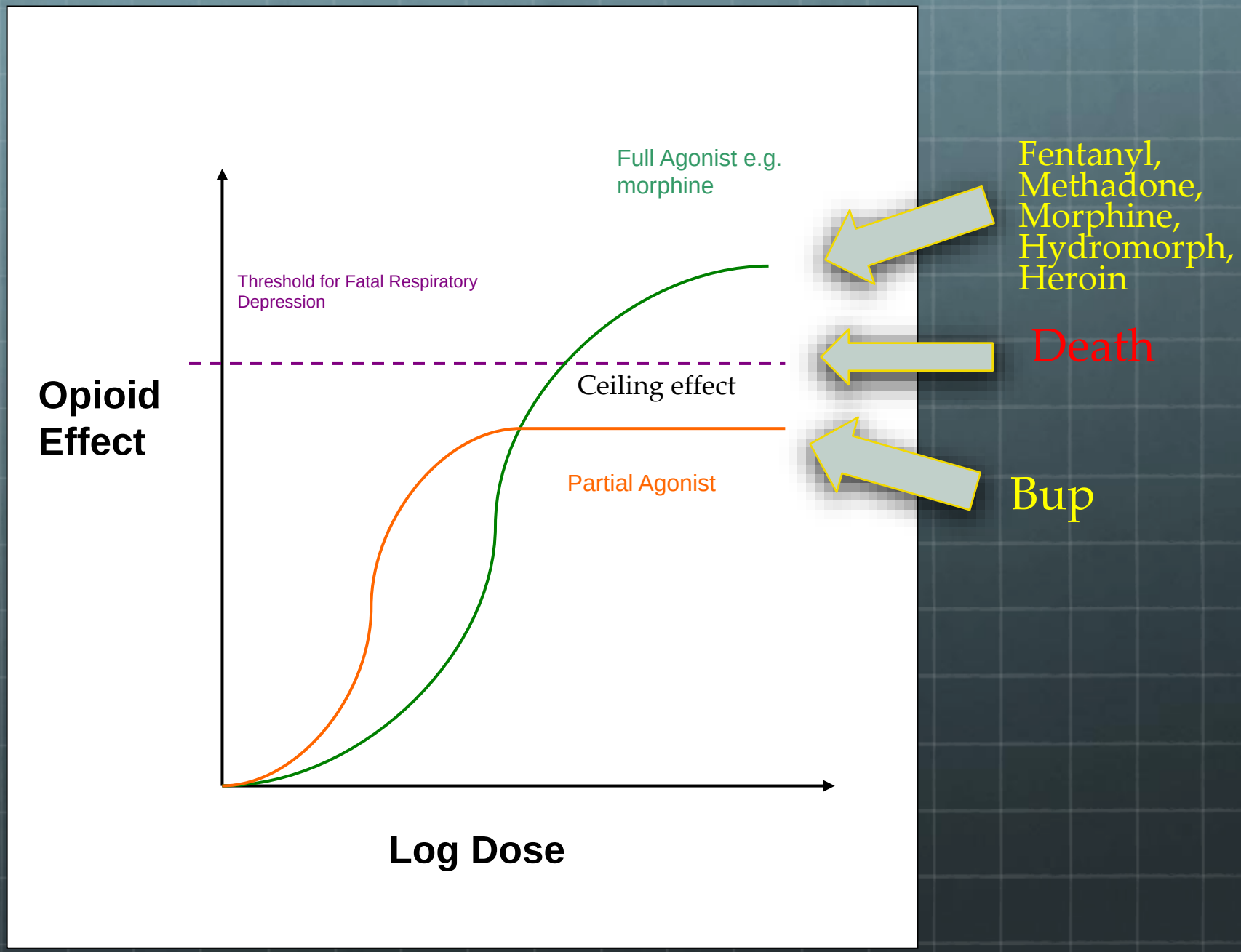
- Much better than Placebo, the same as methadone

At medium/high doses bup/nlx is not markedly different from methadone in terms of treatment retention

- No difference between bup/nlx and MMT in reducing illicit opioid use



(Mattick et al., Cochrane Review 2014)

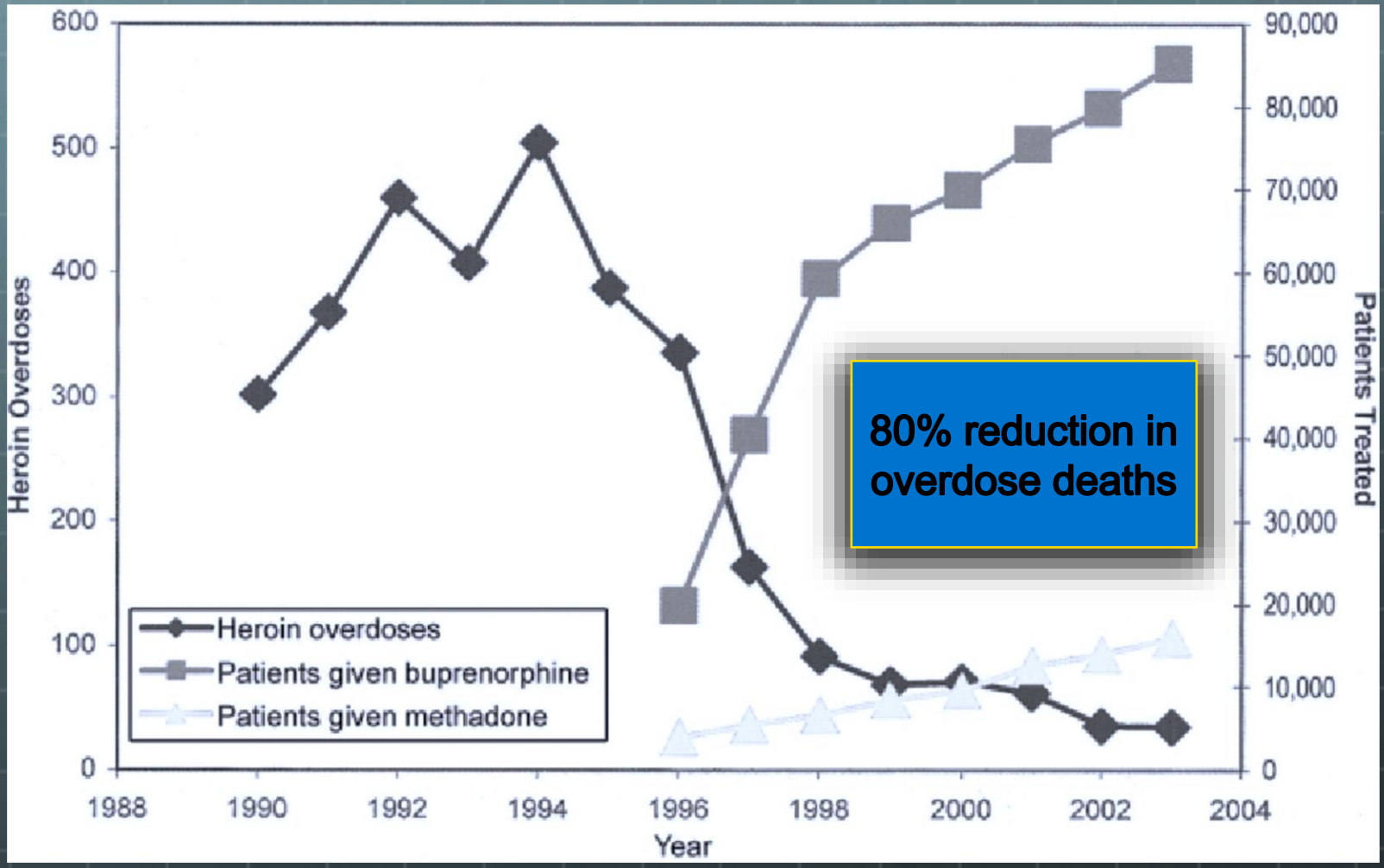

Full Agonist e.g. morphine
Threshold for Fatal Respiratory Depression
Ceiling effect
Partial Agonist
Opioid Effect
Log Dose
Fentanyl, Methadone, Morphine, Hydromorph, Heroin
Death
Bup

Buprenorphine Advantages

- Safer – low overdose risk (6x safer than methadone)
- Shorter time to stable dose (days rather than weeks)
- Doesn't prolong QTc
- Fewer drug-drug interactions
- Fewer risks to public of diverted Bup (easier take home doses, leading to less drop out of treatment)
- You don't need a methadone exemption to prescribe it!

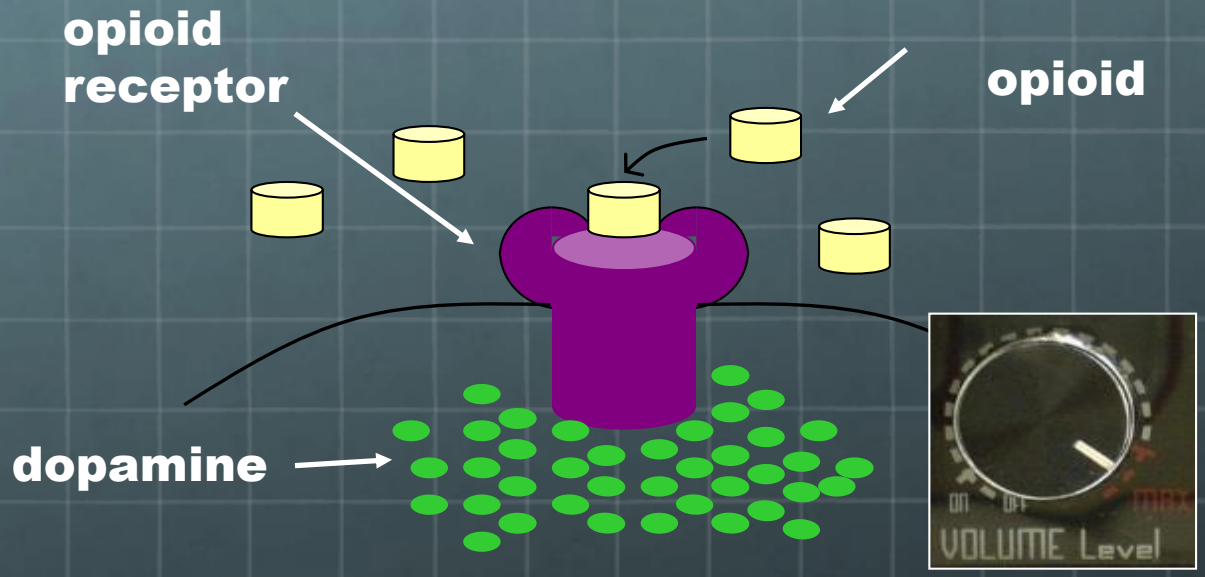
- One tricky thing about it and that is starting people for the first time.

Bup safety data - France



Carrieri et al., 2006

Opioid mechanism of action

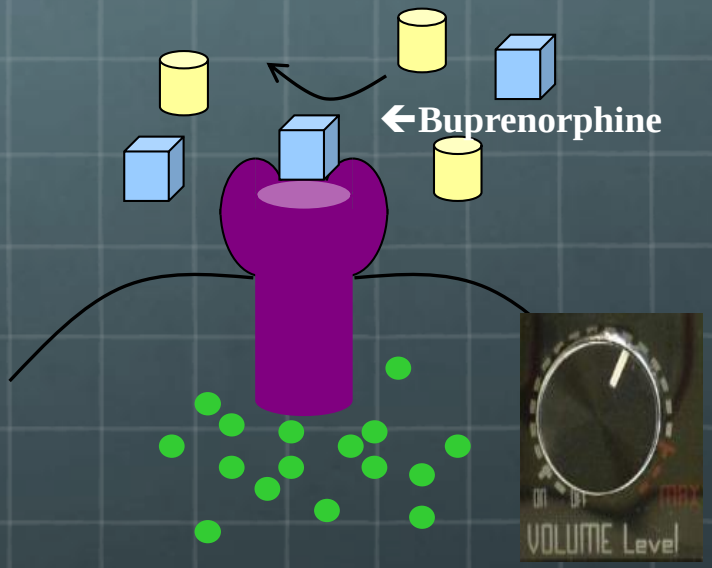


Result:

Receptor Volume 10/10

- Pain Relief
- Intoxication/Euphoria
- Withdrawal Resolution

Buprenorphine mechanism of action



Receptor Volume 6/10
-adequate for resolution of withdrawal

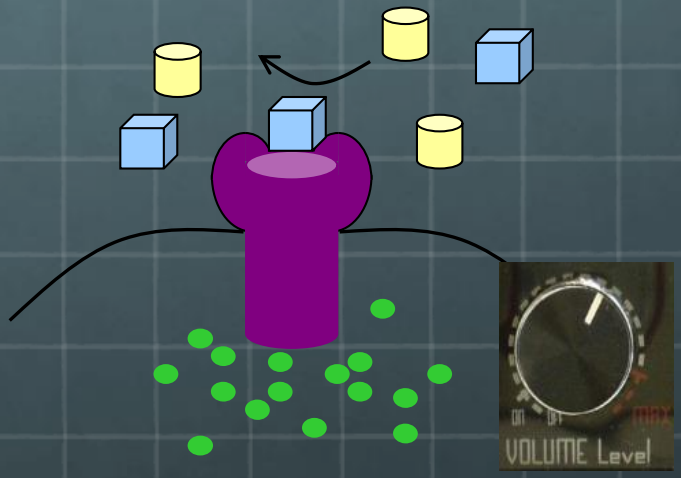
When Starting Bup must be in Withdrawal

(Volume must be low)

Withdrawal- Most receptors unbound

No Dopamine Released

"Volume" on low



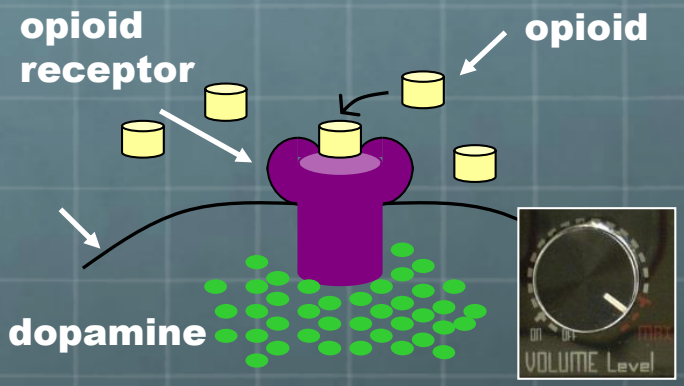
Buprenorphine- binds to receptors, Some Dopamine released, Withdrawal Resolves

"Volume" on medium

Induction

Relative to withdrawal, **buprenorphine** "turns on" receptors more ∴ patient feels better

Precipitated withdrawal

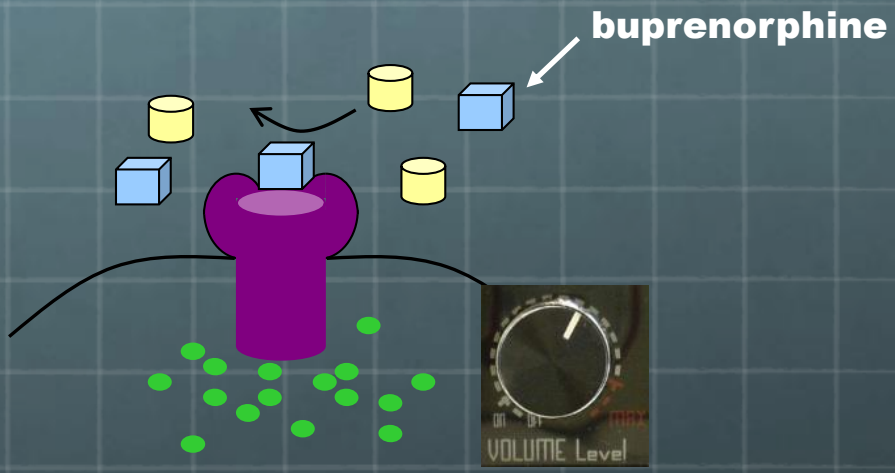


Heroin

Opioid bound to receptors

Full Agonist (High Activation)

"Volume" on max



Buprenorphine

Higher Affinity- Binds preferentially to receptors

Partial Agonist – (Moderate activation)

"Volume" on medium

Precipitated Withdrawal

Relative to intoxication, **buprenorphine** "turns on" receptors less ∴ patient feels withdrawal

Precipitated withdrawal

- Not life threatening
- Abrupt onset after taking Buprenorphine (within 1 hour) but can last 6-12 hours
- Treatment is supportive (more buprenorphine)
- The main downside of PW is that it turns patients off Buprenorphine and we don't want to do this.

2 take home points about Bup

1. High affinity -- binds tightly to opioid receptor
2. Partial agonist – turns volume to medium….

THEREFORE….

The patient must be in opioid mild-moderate opioid withdrawal to initiate Bup, or else you can cause

PRECIPITATED WITHDRAWAL

Especially important if they have taken long acting opioid such as Contin, Kadian or methadone

How do you know the patient is withdrawing

Opioid withdrawal is a clinical syndrome

- Flu-like
- Fluids from every orifice – lacrimation, runny nose, diaphoresis, diarrhea
- Piloerection
- Dilated pupils
- Tachycardia
- Restlessness, agitation, insomnia
- Onset hours after last opioid dose and can last days

Clinical Opiate Withdrawal Scale (COWS)

Flow-sheet for measuring symptoms over a period of time during buprenorphine induction.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date: _____

Buprenorphine induction:

Enter scores at time zero, 30min after first dose, 2 h after first dose, etc.

	Times: _____	_____	_____	_____
Resting Pulse Rate: (record beats per minute) *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120				
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds				
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				

REMEMBER OUR CASE FROM CLOSE BY?

- 46 y.o. M in Sidney
- Service worker, owns own home, elderly parents, financially secure, has a GP
- PMHx: Depression, anxiety
- "High functioning addict"
  - EtOH use disorder since his 20's → multiple attempts at recovery with variable
  - Then got into cocaine
  - 5 years ago got into opioids while on holiday in Mexico

Diagnosing Opioid Use Disorder

1. 4 C's

- Cravings
- Compulsive use (despite desire to stop)
- Consequences (financial/job loss, relationship dysfunction, criminal behaviour, infections, child and family service involvement
- Cut down attempts (or quit attempts) ineffective

2. Physical findings – track marks, abscesses

3. Non-prescribed opioids in UDS

4. Aberrant behaviors with prescribed opioids – running out early, tampering, diversion

He comes through your door… the right one

- Comes in wearing bathrobe and looking terrible
- Tachycardic, sweaty, vomiting into trash bin
- 80 year old parents in wait room
- UDS pos for opioids, nil else
- COWS: 16

Like this except with bathrobe…

Bup initiation

- Before you start: UDS, LFT's if possible, preg test, ensure ongoing prescriber in community, pharmacare coverage
- Having bloodwork on file SHOULD NOT be a precondition or barrier to starting… but you should still get it
- Stop all short acting opioids for at least 12 hours and long acting opioids for at least 24-36 hours, methadone for longer
- Discuss risk of precipitated W/D to patient
- Remember: patient must be in mild – moderate withdrawal to start Bup (COWS >/= 12)
- As with methadone, do not co-prescribe benzos

Sample induction protocol

- Day 1:
  - Give Bup/Nlx 2-8 mg once COWS >/= 12
  - Reassess in 1 hour for precipitated withdrawal.
  - If still in withdrawal (better but not totally better), given an additional 2-4 mg for total max dose of 12 mg on day 1
- Day 2:
  - Assess response to Bup/Nlx on Day 1
  - If w/d sx fully suppressed, keep dose as total dose from yesterday
  - If not fully suppressed increase dose by 2-4 mg (max: 16 mg)
- Day 3:
  - Assess response to Bup/Nlx on Day 2 and follow the same procedure with keeping dose same if w/d suppressed or increasing dose by 2-4 mg (up to max of 20 mg) as needed
  - Max dose of Bup in Canada is 24 mg OD

46 y.o. M in bathrobe

- You write him a prescription for
  - Bup/Nlx 8 mg SL now witnessed ingestion at the pharmacy, then 4 mg SL in 1 hour if symptoms not completely resolved for total of 12 mg SL today
  - Second script given for tomorrow and the rest of the week for
    - "Bup/Nlx 12 mg SL DWI 7/7 Mar 8-14 inclusive. No carries"
    - Advise him to come back sooner on your next clinic days if dose is insufficient

How to write a Bup Rx

If the patient has no carries:

- Buprenorphine/Naloxone (or Suboxone) 12 mg SL od DWI Jan 1-7 inclusive. No carries.

If you are giving the patient carries:

- Buprenorphine/Naloxone (Suboxone) 20 mg SL od DWI Mon-Fri, carries for Sat & Sun. Jan 1-7 inclusive.

46 y.o. M comes back for reassessment

- Comes back to your office 2 days later
- Pharmanet checked – no missed doses
- POC urine: bup only nil else
- Feels and looks so much better! No signs opioid withdrawal.
- Already back to work!
- Feels that dose wears off by early a.m. and is still in withdrawal
- Dose increased to 16 mg od DWI. Rx written for 2 weeks and patient asked to return sooner for dose increase if needed

Bup dose titration

- Target is no drug use and no cravings
- Evidence for better retention in treatment with doses >/= 12 mg
- Can increase by increments of 2-4 mg od to max of 24 mg in Canada (32 mg is max in US)
- Dose dose not NEED to be increased daily though… you can make it work for your particular practice

How long to maintain Bup?

- At least a year or until patient achieves “stability”
  - Consistent negative urines(indicator of no aberrant drug use) and coming to appointments
  - Working
  - Relationships improved
  - Has some insights into triggers
  - Has plan for support through tapering
- Maybe indefinitely… evidence is poor for tapering
  - The brain needs time to heal

Billing for Bup?

- Can just bill office visit…. … or
- T00039 $22.98 Methadone or Bup/Nlx Maintenance
  - Billed once/week regardless of if patient is seen or not (no worry about no shows)
  - Need to see patient at least 2x/month currently (will be reduced to 1x/month soon)
- 15039 Urine Drug Screen $12.42
- Bup initiation code… could currently bill complete examination 00101 $68.01, hopefully will be bup initiation code in the future

Tapers?

Research Summary

Defining dosing pattern characteristics of successful tapers following methadone maintenance treatment: results from a population-based retrospective cohort study.

NOSYK B, SUN HY, EVANS E, ET AL. ADDICTION 2012;107:1621–9.

Ten years: 1996–2006

Outcome:
Sustained successful taper
(no treatment re-entry, opioid-related hospitalization or death for 18 months following last dose)

Out of ***4917*** taper attempts,
646 sustained success (***13%***)

FACTORS

Taper over a *long period* (3 months–1 year)
Taper over 12–52 weeks vs < 12 weeks

+258% increased odds of success

Plan dose reductions to occur bi-weekly or monthly
As opposed to more or less frequently

+61% increased odds of success

How to learn about Bup

www.suboxonecme.ca = 3 hours!

(FREE)

CAMH CME:
http://www.camh.ca/en/education/about/AZCourses/Pages/BUP.aspx

($325, 15 Mainpro M-1)

If you prefer in person training: Suboxone Training day

MAY 27, 8:30-1 p.m. Location TBD

Dr. Chris Fraser presenting

If you're not quite ready to Rx Bup/Nlx

- Know where to send them if ready to start
  - RAAC
  - Cool Aid
  - Pandora Clinic and Outreach Services Clinic (Not same day
- Continue your patients Buprenorphone prescriptions who have been started in Detox/RAAC/Cool Aid
  - You don't need a special exemption to do it
  - If you run into any tricky questions about dose adjustment or monitoring, call us… we are always happy to help

Prevent Overdose

- http://towardtheheart.com/naloxone/
  - Naloxone training videos
  - Stress safe consumption; harm reduction
- Naloxone kits available at
  - RJH ER
  - Cool Aid
  - Aids Vancouver Island
  - Pembrooke

Summary

- Bup/Nlx is first line for treatment of opioid use disorder
- Bup/Nlx is safe
- You do not need a methadone exemption to prescribe Bup/Nlx
- Before June 5th, CPSBC says bup prescribers "should" complete a recognized buprenorphine education program, offered free on May27th
- On June 5th BCCSU takes over from the CPSBC - bup course will not be a required … (although it or some equivalent, will still be helpful)
- Any Family Docs that prescribe opioids should be able to prescribe Bup/Nlx
  - And there are local resources to help you!
    - RAAC, Cool Aid, Pandora, Youth Clinic, AMCS, Provincial RACE line
- Sign-up for Buprenorphine Primary Care Network
  - Support, coordination

Objectives (not going to be in presentation)

- Provide context to the current opioid crisis
  - Where are we in March 2017 and how did we get here?
- Convey key points about addiction that will help docs understand why OAT and Bup specifically is such a key part of the battle against Opioid epidemic
- Review of key points of new guidelines for treatment of opioid use disorder
  - W/D is dangerous, 1Bup, 2methadone, 3. Kadian
- What specifically can family physicians do?
  - Help family docs understand why it is important to Identify opioid use disorder in your practice
  - Help family docs realize what an amazing opportunity they have to make a really big difference
  - Offer evidence based treatment options, mainly Bup/Nlx, methadone, slow release oral morphine
    - And if unable to do this right away then be aware of where to refer patients for timely access to treatment
- Brief Introduction to Bup/Nlx as first line treatment for OUD
  - What is it and how does it work?
  - How do you start and maintain a patient on it?
  - Why is it first line treatment for OUD?
  - How do you become a prescriber?
- Resources for patients and family physicians
- Next Steps for the South Island Community in the Opioid Crisis