Adopting Buprenorphine: Barriers & Incentives

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Topics

- A medication example of moving from clinical trial to clinical practice: Buprenorphine short-term taper at Maryhaven
- Barriers and incentives for adoption of EBPs
Partial vs. Full Opioid Agonist

- **Full Agonist** (e.g., methadone)
- **Partial Agonist** (e.g., buprenorphine)
- **Antagonist** (e.g., Naloxone)

Dose of Opiate

Opiate Effect

Death
Two, open-label, randomized clinical trials, residential & outpatient.

Compared Buprenorphine-Naloxone ($n = 77$) and Clonidine ($n = 36$) for 13 day opiate detoxification in residential.

Initiated in 6 Community Treatment Programs.

Outcome:

- BUP/NX = 77% (59) Present and Clean on day 13
- Clonidine = 22% (8) Present and Clean on day 13

Do Research Findings Translate into Clinical Care?

- Maryhaven held meetings with clinical staff and community stakeholders to discuss the value of this new treatment.
- State, County and private funding was acquired to train staff and support the treatment of 104 patients in a one year period.
- Maryhaven implemented buprenorphine-naloxone (BNX) in its detoxification program in August 2003.
- This report is based on a retrospective chart review of the first 64 BNX patients and data for 384 additional admissions for opioid-dependence prior to and after BNX became available at Maryhaven.
Why Adopt This Treatment?

“We must find a better way to treat these patients, more that half of them are not continuing with treatment”

Maryhaven Medical Director
Three Groups

- Prior to BNX implementation, \( n = 157 \)
  - Admitted prior to BNX Implementation between 6/10/03 - 8/24/03

- After BNX implementation but no BNX, \( n = 227 \)
  - Admitted between 8/25/03 - 1/31/04, but did not take BNX

- Received BNX, \( n = 64 \)
  - Admitted between 8/25/03 - 1/31/04 and received BNX
<table>
<thead>
<tr>
<th>Day</th>
<th>BNX Dose (mg of bup)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Darvocet N 100, Clonidine 0.1mg po tid &amp; Lorazepam 1 mg.</td>
</tr>
<tr>
<td>1</td>
<td>4 plus 4 more if not contraindicated (subutex for 1st dose if long-acting)</td>
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<tr>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>16</td>
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<td>4</td>
<td>14</td>
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<td>8</td>
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<td>8-9</td>
<td>6</td>
</tr>
<tr>
<td>10-11</td>
<td>4</td>
</tr>
<tr>
<td>12-13</td>
<td>2</td>
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</tbody>
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Patient Demographics

- Female
- Male
- African American
- White

Prior to BNX
No BNX
BNX

% of Patients
# BUP/NX Group: Dose and Retention

<table>
<thead>
<tr>
<th></th>
<th>Mean (S.D.)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BNX Dose (mg)</strong></td>
<td>22.8 (10.2)</td>
<td>0-32</td>
</tr>
<tr>
<td>n=58</td>
<td></td>
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<tr>
<td><strong># Days on BNX</strong></td>
<td>14.5 (6.9)</td>
<td>1-22</td>
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<tr>
<td>n=63</td>
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Treatment Completion & Engagement

A

Completed Detoxification Program

- Prior To BNX
- No BNX
- BNX TX

% of Patients

* p = .0001

B

Continued Early TX Engagement

- Prior To BNX
- No BNX
- BNX TX

% of Patients

IOM Report: Bridging the Gap Between Practice & Research

- Structural
- Financial
- Educational
- Stigma
- Policy

Barriers: Structural

- Services develop in response to directives and regulations of funding & certifying bodies.

- Examples:
  - No billing for couples & family therapy,
  - Lack of medical staff in outpatient programs.

- Maryhaven staff lacked experience with agonist treatment for opioid dependence.

- Extended stabilization limited by physician availability.

Barriers: Financial

- Public services are under-funded & private third party payment is highly restricted.
- Practice may be developed to access resources rather than to address specific clinical needs.
- To maintain resources programs may avoid controversial treatments (contingency management, methadone).
- **ODADAS:** We don’t regulate it and we don’t fund it.
- Numerous state, county, and private stakeholders were interested in funding methadone alternatives.

Barriers: Educational

- Awareness of a treatment is an essential but not sufficient condition for adoption, training remains a challenge.
- Therapist trained “on the job” are less likely to have training in or access to information on EBTs.
- Even when motivated to adopt EBTs access to adequate.
- Approved physician trainings and waiver process were readily available.
- More recently through NIDA/SAMHSA Blending Team products multi-disciplinary trainings are available.

Barriers: Stigma

- Substance abuse field has a unique burden of stigma, this can be seen in the NIMBY phenomena.
- Lack of advocacy groups such as: American Heart Assoc., American Cancer Society, & American Lung Assoc.
- These organizations can raise funds, influence policy makers, and educate consumers.
- Worked to the advantage of BUP/NX to some degree: funders expressed relief to have an alternative to the highly stigmatized methadone.
- Partial agonist carried stigma with staff not experienced with or having negative experiences with agonist treatment.

Barriers: Public Policy

- Unlike other illnesses may be justified on public safety rather than public health basis.
- Costs evaluated relative to incarceration rather than improvement in quality of life.
- Policy often influenced by public opinion rather than empirical evidence (ban methadone and offer detox).
- Initially providers limited to 30 patients total. Maryhaven admits over 600 opiate dependent individuals annually.
- Now individual physicians limited to 30 patients total. Maryhaven has 3 qualified physicians.

Incentives

- **Policy Incentive**
  - DATA 2000
  - 2002 FDA approves BUP for drug abuse and it becomes available for clinical use in January 2003

- **Prestige of offering state of the science treatment**
  - Recognition by stakeholders at State & Regional Meetings

- **Intrinsic motivation to do the best possible job**
  - When a treatment works, providers are exposed directly to those results.
Incentives: Patient Level

❖ Barriers
  ▪ Early complaints of W/D with higher doses
  ▪ Medication diversion

❖ Incentives
  “It’s a miracle, really!”
  ▪ Patients requesting BUP/NX at admission
  ▪ Less anxiety about detoxification

Incentives: Counselor Level

❖ Barrier
  ■ “I’m not sure that this easy detox is such a good idea”
    Detox Counselor

❖ Incentive
  ■ “The difference is unbelievable these patients now have a fair chance at treatment & recovery”
    Rehab nurse
  ■ “It’s amazing you can sort them out by who is sick and who is ready to participate in treatment”
    Detox Counselor
Barriers

- Concern about expense of medication
- Concerns about adopting an agonist medication

Incentives

- Additional funding for BUP/NX adoption
- Positive exposure in the media
- Better patient retention
- More staff satisfaction
- Positive recognition by funding & certifying bodies
BUP/NX Adoption
Ingredients for Success

- Started with obvious opportunity for improvement
- Training and technical assistance readily available
- Presence of well positioned champion or change agent(s)
- An EBP with a large effect size that is very forgiving