Suboxone Best Practice Guidelines
Value Behavioral Health of Pennsylvania, Inc.
Final (OMHSAS Approved AUG15)

Background

There is an exponential increase in the use and availability of opioid medications. Americans, who constitute only 4.6% of the world's population, have been consuming 80% of the global opioid supply and 99% of the global hydrocodone supply (American Society of Interventional Pain Physicians). With the expansion of opioid use, there has been an increase in the number of deaths associate with opioid overdoses. Last year alone, the number one cause of death in 17 states was prescription drug abuse, surpassing motor vehicle accidents (CDC and Prevention). No longer is an opioid use disorder seen as the plight of "street addicts." Opioid addiction now includes middle-class, white collar employees, and their family members. Due to socio-economic status, self-identity, and stigma associated with traditional opioid treatment methods, these individuals often resist traditional drug treatment programs or avoid treatment altogether.

Suboxone, a partial agonist, was developed as an alternative to traditional treatments for opioid dependence. It is an orally administered medication. Suboxone received its approval from the FDA in 2002 and can be prescribed by qualified physicians for the treatment of individuals with opioid dependence. Suboxone is a combination of two medications: buprenorphine and naloxone. Buprenorhine blocks the effects of most other opioids and minimizes withdrawal symptoms by partially blocking the opioid mu receptor. The naloxone has been added to decrease the possibility of diversion and abuse. This is the recommended preparation for induction, detox, and maintenance for the treatment of opioid dependence.

Suboxone can be prescribed and monitored through outpatient means in the physician's office (i.e., outside of the traditional methadone clinic) by qualified physicians who hold a waiver from the special registration requirements defined in the Drug Addiction and Treatment Act of 2000 (Treatment Improvement Protocol Series No. 40, Center for Substance Abuse Treatment, Rockville, MD, SAMHSA 2004). Requirements for this waiver include such things as current state licensure, addiction certification or completion of a training program. Once registered, the physician can initially treat up to 30 individuals at a time. After one year, a physician can treat up to 100 individuals at a time. This allows individuals with opioid dependence to receive treatment that is both discreet and convenient.

The benefits of an office-based treatment regimen such as this are many. They include possible medical-cost offsets, decreased relapse rates, and allowing individuals to remain in the community and at work during treatment. In addition, this offers an acceptable and effective treatment alternative for those individuals who may have avoided treatment in the traditional manners due to stigma, socio-economic status, or self-identity.

Suboxone has been a complicated issue in Pennsylvania. Over time, it has undergone a number of changes in terms of service delivery, treatment models and payment systems. SAMHSA TIP #40 offers some suggestions for best practices. According to TIP #40, those medication assisted programs that utilize regular, structured substance abuse counseling have better outcomes than those that provide little or no counseling. Family and community involvement also appears to be correlated with better outcomes in medication assisted treatment. The TIP suggests ongoing education for the member in physical issues associated with addiction, along with behavioral health concerns. Drug testing can also be a useful tool in treatment. Despite the Substance Abuse and Mental Health Services Administration

(SAMHSA) Treatment Improvement Protocol (TIP # 40) on "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction," there are still wide variations in clinical practice. According to a study conducted by the University of Pittsburgh in 2014, 78.3% of Suboxone prescriptions are written by primary care physicians while psychiatrists accounted for only 11.1%. One third of Suboxone users in this study were also receiving prescriptions for other opioids while 40 % had an overlapping claim with a benzodiazepine prescription. Equally disturbing was the finding that 26% of individuals receiving a prescription for Suboxone did not have a diagnosis of opioid dependency.

A 2013 SAMHSA report (The DAWN Report, 1/29/13) showed a ten-fold increase in Suboxone related US Emergency Department visits between 2005 and 2010. In addition, a VBH-PA study of 2923 distinct members who were prescribed Suboxone in 2010 found that the vast majority of members (73%) did not receive any drug and alcohol support services along with their Suboxone.

Key Problems with Current Suboxone Treatment Practices

1. Lack of concurrent D&A treatment with Suboxone administration.
2. Detoxification with no follow-up services.
3. Diversion/misuse/selling Suboxone on the street.
4. Use of other illicit substances with Suboxone.
5. Members are not responding to Suboxone treatment but not are not being stepped up to more intensive treatment or referred to their Single County Authority (SCA) for further evaluation.
6. Physician prescribers who are not connected to a HealthChoices or Medicaid network and are not following generally accepted treatment principles.
7. Some reluctance by D&A treatment providers to have members taking Suboxone in their treatment programs.
8. Lack of effective use of urine drug screens (both to screen out drugs of abuse and "screen in" Suboxone use).
9. Little individualized treatment planning in some service descriptions.
10. Limited use of community supports or linking with community supports.

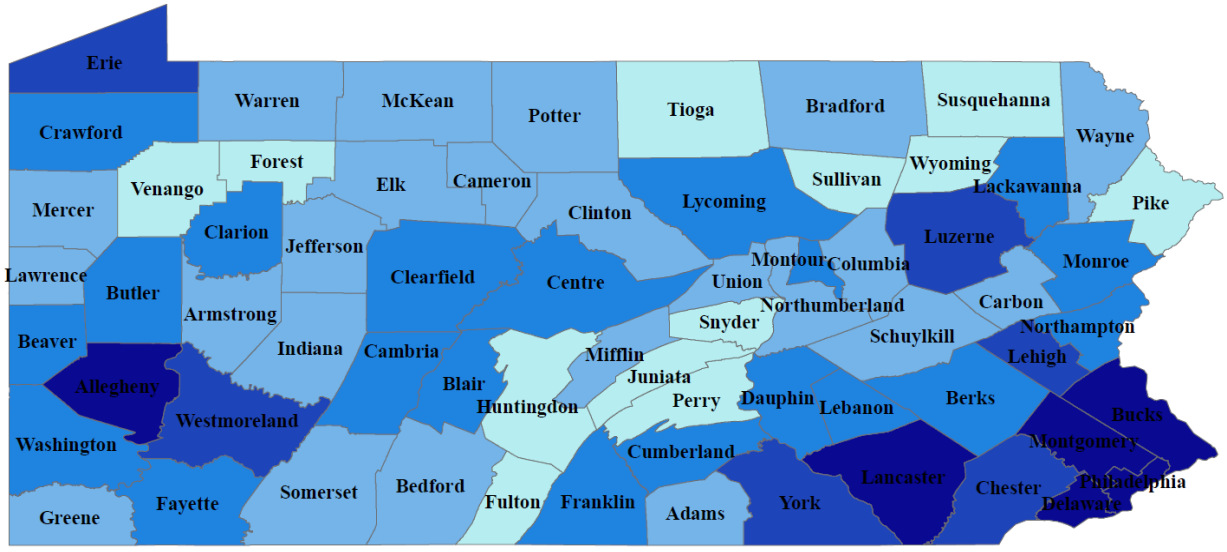
Best Practice Guidelines for Physicians Prescribing Suboxone*

***** Suboxone treatment at Methadone Assisted Treatment Programs will also follow these best practice guidelines.

Item #	Best Practice Guidelines	Comments
1	The Best Practice Physician (BPP) or the Licensed Facility (LF) out of which they practice will comply with all state and federal guidelines regarding the prescribing of Suboxone.	
2	The BPP/LF will conform to well accepted practice guidelines such as "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction," A Treatment Improvement Protocol (TIP 40) issued by the Substance Abuse and Mental Health Services Administration.	
3	The BPP/LF will be credentialed and in good standing with a HealthChoices MCO (either PH-MCO or BH-MCO) by July 1, 2015.	
4	The BPP/LF will have written policies and procedures regarding: A Suboxone Member Treatment Agreement which outlines member rights and responsibilities. Sample plans are available at www.csam-asam.org and on the SAMHSA website at (http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf)	
5	The BPP/LF will have written policies and procedures assessing when to discontinue Suboxone treatment due to a lack of response. This includes consideration of a referral back to Single County Authority (SCA) or other D&A resource for further screening and referral to a different level of care. The reason for discontinuation and referral should be thoroughly documented in the medical record.	
6	The BPP/LF will encourage and support appropriate follow-up with community supports (such as 12 step programs) when indicated. The BPP/LF will have copies of community resources for new patients that includes treatment providers, crisis line number, the SCA, etc.	
7	The BPP/LF will have written policies and procedures on abstinence from alcohol and other drugs. In support of this, the BPP/LF will effectively screen and monitor for signs of concurrent drug use. When this is noted, the BPP/LFF will take appropriate steps to support the member's recovery. These may include discontinuation of Suboxone therapy and referral to another level of care, referral back to SCA, contacting the MCO for other referrals or other D&A resource for further screening and recommendations. These policies will be clearly communicated to the member in the member agreement.	
8	The BPP/LF will have written policies and procedures to minimize diversion (the may include such best practices as policies to address "lost scripts", conducting pill counts, urine drug screens to detect buprenorphine and its metabolites, etc.)	
9	The BPP/LF will have written policies and procedures regarding: Supporting and encouraging member participation in drug and alcohol counseling/therapy as this combination has been shown to be a critical component of successful treatment with Suboxone. The BPP/LF will verify adherence with counseling by communicating with the D&A treatment provider on a routine	

	basis. These contacts will be documented by the BPP/LF and will include additional steps to support and ensure participation in D&A treatment. These policies include member responsibilities as well including keeping appointments, not sharing or selling medication and adhering to their treatment plan. In the absence of adequate participation in D&A treatment, despite efforts to educate and support the individual, the BPP/LF will discontinue Suboxone treatment and make a referral to another level of care, a referral back to the SCA or other D&A resource for additional support and treatment.	
10	The BPP/LF will encourage family and social support involvement in D&A treatment and document these efforts.	
11	The BPP/LF will take an active role in providing education on substance abuse, mental health issues, relapse, relapse prevention, and medical issues associated with substance use.	
12	The BPP/LF will monitor the use of other prescription drugs and have written policies to address concurrent use of benzodiazepines and other opioids.	

County-Level Variation in Availability of Suboxone Prescribers*



 # prescribers: 0 | 1 - 5 | 6 - 15 | 16 - 30 | > 30

(2012 overll numbers of buprenorphine prescribers: mean= 11; median= 5; minimum=0; maximum=131)

*Julie Donohue, Health Policy and Management, University of Pittsburgh 2014