

# **2014 Buprenorphine Summit**

**September 22–23, 2014  
Report of Proceedings**

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**U.S. Department of Health and Human Services**  
Substance Abuse and Mental Health Services Administration  
Center for Substance Abuse Treatment  
Division of Pharmacologic Therapies

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Rockville, MD 20857

## Acknowledgments

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), and the National Institute on Drug Abuse (NIDA), U.S. Department of Health and Human Services (HHS), by JBS International, Inc., under contract number HHSS283200700003I/HHSS28342007T. Melinda Campopiano von Klimo, M.D., Medical Officer, Division of Pharmacologic Therapies (DPT), CSAT, SAMHSA, HHS, served as the primary medical advisor, and LCDR Brandon T. Johnson, M.B.A., Regulatory Compliance Officer, DPT, CSAT, SAMHSA, HHS, served as the Contracting Officer's Representative.

Special appreciation is extended to Wilson M. Compton, M.D., M.P.E. (NIDA), H. Westley Clark, M.D., J.D., M.P.H. (SAMHSA), and Elinore McCance-Katz, M.D., Ph.D. (SAMHSA), for their efforts in planning the Summit.

Bonnie Wilford, M.S., and Susan Hayashi, Ph.D., served as the Project Directors, with valuable assistance from Gwen Solan Littman, M.D.; Joseph G. Perpich, M.D., J.D.; Krystyna Isaacs, Ph.D.; and Jeffrey Vender, M.L.I.S., of JBS International, Inc.

The valuable input of the 2014 Summit Steering Committee (see Appendix A) is acknowledged with gratitude.

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## BACKGROUND

Buprenorphine received Food and Drug Administration (FDA) approval for use in opioid addiction treatment in October 2002, and as a partial agonist it has some clear advantages over other forms of treatment for opioid addiction. Still, 13 years later, many of those who would benefit from such treatment are not offered buprenorphine as an option. On September 22–23, the 2014 Buprenorphine Summit (Summit), a meeting of expert professionals, was convened by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), in partnership with the National Institute on Drug Abuse (NIDA). The meeting was convened to gather the perspectives of leaders from the field regarding the state of practice and their assessment of possible strategies for moving forward. This Summit presented an opportunity for active and collaborative discussion about caring for patients; designing, operating, and sustaining programs; supporting recovery; and training providers. The participants explored what is known about the adoption of buprenorphine to treat opioid use disorder (OUD), reasons why it has not been as widely prescribed as might have been expected, and ways that federal agencies, medical professionals, and concerned individuals might enable buprenorphine treatment to become more accessible.

The participants in the 2014 Buprenorphine Summit were 32 nonfederal individuals and 37 staff members from 9 federal agencies along with 14 observers: 9 individuals representing medical professional organizations and 5 representatives from 2 pharmaceutical companies. An additional 24 people attended the Summit virtually, as the presentations and general discussion sessions were made available via live WebEx sessions. The virtual participants were invited to submit questions via the messaging system. (See Appendix B for a list of participants and observers, including participants in small work groups.)

The meeting was structured around five major topics:

1. Access to Buprenorphine: Patient Capacity and Quality Care
2. Access to Buprenorphine: Workforce Considerations
3. The Role of Provider Training in Improving Access
4. Buprenorphine for an Opioid Use Disorder in Special Populations
5. Addressing Health Systems and Reimbursement

Multiple speakers addressed each topic in a major presentation session, followed by a 1-hour participant discussion session. On the second day, after the fifth major presentation session, participants and observers broke into small work groups to discuss in more detail the topics addressed in the five major presentation/discussion sessions. Each small group was challenged to identify actionable strategies to achieve specific benefits to assess the scope of problems or the impact of possible solutions. A number of shorter presentations by guest speakers were offered as well. (See Appendix C for the agendas for both general sessions and work groups and Appendix D for treatment models discussed at the Summit.)

Prior to the meeting, participants were provided access to a bibliography of peer-reviewed papers published since 2007 on buprenorphine and buprenorphine treatment, and they were invited to supplement it with other background materials via a password-protected Web-based portal. The bibliography and participant submissions can be found in Appendix E.

These proceedings present a summary of the major points made in the Summit. In-depth Summit discussions of all topics, in both general sessions and work groups, were captured in notes and transcripts that will be used by SAMHSA in future planning.

## KEY POINTS ON THE FIVE MAJOR TOPICS

The guest speakers' presentations, the highlights of the corresponding discussion session, and each work group's report to the general session are summarized below for each of the five topics.

### 1. Access to Buprenorphine: Patient Capacity and Quality Care

#### Presenters

- Miriam Komaromy: *Provider-level Barriers to Buprenorphine Adoption*
- Jinhee J. Lee: *DEA ARCOS Trend Analysis–NTP Buprenorphine Purchases*
- Christopher M. Jones: *Trends in Need Versus Capacity for Opioid Agonist Therapy*

#### Key Points of Presentations

##### Some reasons DATA 2000 waived physicians are not prescribing buprenorphine:

- They have no practice partners who have waivers or can provide cross-coverage because of the interpretation of the patient limit.
- They lack institutional support.
- Their community lacks psychosocial resources for patients.
- They feel that with current patient limits they cannot treat a sufficient volume of patients to meet all the costs of providing buprenorphine given current third-party reimbursement.
- The regulations and scrutiny particular to prescribing buprenorphine make them feel as if they are doing something suspect by prescribing it.
- They are concerned about auditing visits from the Drug Enforcement Administration (DEA).
- Confidentiality rules make it difficult to integrate addiction care with primary care.

##### Strategies to address these concerns:

- Consider patient co-management across disciplines and consultative approaches.
- Increase the number of buprenorphine patients a prescriber is allowed to treat. (A range of possible numbers and stipulations was offered.)

- Educate the boards of directors of treatment programs toward attitudinal change so that more treatment programs will provide buprenorphine and psychosocial services for patients on buprenorphine.
- Identify or work toward development of up-to-date medical management guidelines.
- Urge DEA monitoring through prescription drug monitoring programs (PDMPs) rather than by unannounced auditing visits.
- Provide financial incentives to physicians and clinics offering buprenorphine treatment.
- Explore the feasibility of reducing or eliminating some restrictions on prescribing buprenorphine (e.g., prior authorization, arbitrary limits on dose and treatment duration, limit on number of patients) and enabling advanced practice nurses (APNs) and physician assistants (PAs) to prescribe.
- Consider using professional or career incentives to recruit resident physicians to the area of addiction treatment.
- Improve resident training to include medication-assisted treatment (MAT).
- Train pharmacists to take on more responsibility related to buprenorphine treatment such as medication monitoring and compliance.

**Program models discussed:**

- Project Extension for Community Healthcare Outcomes (ECHO) uses case-based video teleconferencing for mentoring of geographically widespread primary care providers (PCPs) to extend access to treatment to more communities.
- The Baltimore Buprenorphine Initiative model features dissemination of—and connection to—specialty primary care services in particular.
- The BeeHIVE Program at University of California, San Francisco, integrates buprenorphine therapy into a human immunodeficiency virus (HIV) primary care setting.

**Strategies to reduce the risk of buprenorphine diversion and misuse:**

- Utilize a written informed consent and treatment agreement, establishing ground rules and boundaries to guide patient adherence to the treatment plan.
- Write prescription orders that are complete and clear; respond promptly and completely to pharmacists' questions or requests for verification; avoid early refills.
- Prescribe no more than the number of doses needed.

**Key Conclusions of Work Group****Proposed strategies:**

- Identify buprenorphine/naloxone (not monobuprenorphine) as the preferred product.
- Provide standards for prescribing buprenorphine/naloxone to reduce or prevent diversion such as:
  - Patient monitoring by clinicians
  - Effective dosage ranges and schedules
  - Refills
  - Dealing with lost medication or prescriptions.

- Increase the amount of reimbursement health professionals receive for providing MAT with buprenorphine.
- Look at residencies and get residency review committees involved; trained preceptors are needed to model behavior.
- Decrease or discontinue in-person, or especially unannounced, audits by the DEA.
- Develop guidance on the use of telemedicine in MAT with buprenorphine, perhaps with a role for APNs or PAs.
- Consider the Massachusetts Nurse Care Management (NCM) model for enhancing infrastructure (providing a paid, embedded, full-time staff person for every 50 patients) as a replicable strategy to expand access to buprenorphine.
- Consider the Vermont hub-and-spoke model (centers of excellence conduct patient assessment and induction, get them stabilized, and then identify dispensing stations for maintenance) as a possibly replicable model to expand access to buprenorphine.

**Needs identified:**

- Provide quality metrics and structures for monitoring care that include:
  - Urine toxicology screens
  - Informed consent forms
  - Use of the PDMP
  - Use of referral systems.
- Develop continuing medical education (CME) credits.
- Obtain knowledge and data about diversion of various formulations or dosages relative to one another.
- Review and consider revising DATA 2000 to reflect the current practice environment. Opioid use has reached the level of national crisis since DATA 2000 was enacted, and APNs and PAs have become a larger, more widely accepted, and more available part of the healthcare workforce.

## 2. Access to Buprenorphine: Workforce Considerations

### Presenters

- Colleen LaBelle: *Integrated Approach to Treatment Expansion*
- Wayne Wakeland: *Buprenorphine Treatment Capacity: A Descriptive Agent-based Model*

### Key Points of Presentations

**Strategies for an integrated approach to treatment expansion:**

- Use APNs and PAs rather than registered nurses (RNs) for in-office support services for patients on buprenorphine. APN and PA services can be billed to Medicaid.
- Consider requiring training on addiction and MAT for licensure of nurses, APNs, substance abuse counselors, certified alcoholism and drug abuse counselors, and mental health providers.



- Increase collaborative partnerships across disciplines in the delivery of buprenorphine treatment.
- Consider using Treatment Research Institute-developed medical school curriculum online, now being used by 134 medical schools around the country, or a similar resource.

**Program models discussed:**

- Massachusetts NCM model: RNs with 1 day of training support physicians by performing patient education and following treatment protocols (e.g., urine drug testing, pill counts, perioperative management); ensuring compliance with federal laws (e.g., confidentiality, record keeping); coordinating care with other physicians, pharmacists, and offsite counseling services; handling drop-in hours for urgent issues; and addressing all insurance issues (e.g., prior authorizations).
- Stanley Street Treatment and Resources (SSTAR), Fall River, Massachusetts: Patients initially see physicians, then return weekly for 12 weeks to meet with the doctor and/or with a nurse; medical team meets biweekly to go over cases; money made by billing for nurse visits offsets money lost billing for counseling.
- Hub-and-spoke model in Vermont: See description on page 4.
- Federally qualified health centers (FQHCs): Structure allows sustainable reimbursement—enhanced Medicaid reimbursement with NCM model and Medicare deductibles waived.

**Buprenorphine treatment capacity:**

- Based on the number of DATA 2000 waived physicians, there is capacity to treat 1.4 million people. If fully realized, the potential exists for many more people to receive treatment. This could far exceed the number of people currently receiving MAT in opioid treatment programs (OTPs).
- Factors favoring access to buprenorphine for OUD treatment:
  - It can be prescribed in office-based settings and dispensed at any licensed pharmacy.
  - Medicaid and private insurance funding for buprenorphine/naloxone should be increasingly available because of the Affordable Care Act (ACA) and parity legislation.
- Factors limiting access to buprenorphine:
  - The current actual capacity to provide OUD treatment is not adequate to meet the need for treatment.
  - An individual physician is limited in the number of patients he or she can treat.
  - Prescribing buprenorphine as a part of MAT involves more management and care coordination than most primary care physicians have available.
  - Many physicians refrain from providing buprenorphine treatment because of fear of possibly disruptive inspections or audits by DEA agents.
  - Many physicians do not provide buprenorphine because the patient caps limit options for patient coverage during physician absence or illness.

- Only physicians can prescribe buprenorphine for OUD treatment.

## Key Conclusions of Work Group

### Strategies to expand availability of buprenorphine treatment for OUD:

- Examine elimination of restrictions on prescribing buprenorphine:
  - Enable APNs and PAs to prescribe it.
  - Raise the cap on how many patients a physician can have in treatment at a time.
  - Allow physicians to cross-cover one another's patients on a short-term basis without being in violation of the patient limit; the practice of courtesy cross-coverage is standard across medicine.
- Work with state Medicaid programs to remove current barriers to prescribing:
  - Provide reimbursement for providers adequate to fully offset costs.
  - Remove arbitrary limits on dosage and time in treatment, prior authorization, "fail first" requirements, and mandatory counseling attached to buprenorphine therapy.
  - Reimburse for time spent and service provided via telehealth.
  - Reimburse for NCM programs.
- Encourage care management in the form of cross-agency care coordination (Missouri system).

## 3. The Role of Provider Training in Improving Access

### Presenters

- Andrew J. Saxon: *Impact of Current Training Requirements*
- Stephen Wyatt: *Training in Support of Adoption and Implementation*

### Key Points of Presentations

#### DATA 2000 waived physicians' main barriers to prescribing:

- Lack of psychosocial support
- Time constraints
- Lack of confidence
- Lack of specialty backup
- Resistance from practice partners

#### Strategies to address these barriers:

- Embed addiction/mental health personnel to help handle logistics, provide some of the counseling, and create an adequate reimbursement model.
- Offer professional support via Providers' Clinical Support System (PCSS) or similar education/mentoring resource.
- Encourage and expand telemedicine.
- Work with DEA to destigmatize buprenorphine prescribing for providers.

**Current training course for physicians:**

- Goal: Inform physicians on the safe and appropriate clinical use of buprenorphine and on the resources needed to set up office-based opioid agonist treatment (OBOT) using it.
- Nine training topics: Cover over 8 hours of training.
- Formats: Lectures and small groups can be face-to-face, self-training, or a combination.
- Key evaluation finding: Training must help prescribers develop the skills and confidence needed to manage patients with substance use disorder (SUD).

**Strategies to support provider buprenorphine training to improve access to care:**

- Expand outreach to providers through a coordinated effort of SAMHSA and PCSS-MAT or similar partnership.
- Promote ongoing continuing professional education with standard evidence-based interventions and strategies for successful buprenorphine treatment.
- Provide new, expanded funding for improved CME activities and required buprenorphine training.
- Consider new options for promoting interest and willingness to engage in training and provide buprenorphine treatment.
- Fund Coalition on Physician Education in Substance Use Disorders or similar organization to develop a unified curriculum standard for medical school education in addiction medicine or promote the adoption high-quality existing curricula.
- Increase the number of addiction specialty fellowships available.
- Address difficulties with being credentialed at a hospital if a provider wants to use a DATA 2000 waiver and other institutional barriers.
- Consider requiring ongoing training to maintain DATA 2000 waiver.
- Encourage state medical boards to use Federation of State Medical Boards (FSMB) revised OBOT guidelines released in April 2013.
- Increase public awareness and understanding of buprenorphine treatment to promote acceptance and reduce barriers.
- Enable APNs and PAs to become prescribers or provide some meaningful, billable function related to buprenorphine treatment that is linked to expanding the prescriber capacity.
- Promote culture change in healthcare institutions regarding their responsibilities and roles in addressing public health priorities.
- Help consumers and their support systems make their voices heard to promote greater access to care.

**Training model discussed:**

- Course on Addiction and Recovery Education (CARE) at MedU (an online medical education program)

**Treatment guideline models discussed:**

- FSMB's 2013 Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain
- New MAT guidelines to be issued by the American Society of Addiction Medicine (ASAM) (anticipated release in Spring 2015)
- Vermont's buprenorphine office-based treatment guidelines that are updated every 2 years and are moving OTPs toward meeting National Committee for Quality Assurance specialty standards

**Specific strategies to improve quality of medical school and postgraduate curricula:**

- Physician education should ensure that students work with physicians who champion treatment for OUD and/or participate in treating a patient with buprenorphine.
- SAMHSA and other federal agencies could partner with medical education authorities and medical school deans to better align curricula with the unmet public health need for addiction prevention and treatment.
- The Centers for Medicare and Medicaid Services' (CMS) investment in graduate medical education can leverage redesign of curricula to reward desired outcomes, competencies, and program performance specifically as they pertain to addiction treatment.
- SAMHSA and other federal agencies could partner with young doctors through trainee and student organizations (e.g., Doctors for America, the American Medical Student Association, house staff organizations) to counter stigma about addiction, reinforce physicians' responsibility to treat all patients in need, and promote use of effective OUD treatments.

**Key Conclusions of Work Group****Strategies to support provider training to improve access:**

- Work with the National Governors Association (NGA) or Governor's Institute on Substance Abuse; ask governors to leverage influence with state medical schools to revise the curricula.
- Look at creating specific training pathways leading to DATA 2000 waivers for physicians based on stage of training/career, specialty, practice environment, etc.; a PCSS group is looking at this.
- Obtain reimbursement for peer support or case management.
- Increase educational opportunities and resources for nonphysician stakeholders, especially pharmacists.
- Consider whether state-required CME to maintain licensure should be recommended to include training in MAT.
- Examine how physicians are trained for MAT with methadone for lessons learned.
- Explore adaptation of FDA Risk Evaluation and Mitigation Strategy programs to include training in MAT.
- Consider incentivizing training, perhaps by tying it to licensing of FQHCs or certification of the medical home or requiring it of OTP directors.

- Encourage adoption of FSMB buprenorphine guidelines for opioid prescribing passed at the state level.
- Increase acceptance of MAT as a standard first option for opioid dependence treatment via short, specific educational messages (e.g., created with SAMHSA or NIDA support) to be delivered over the American Medical Association Wire and to Association of Medical Colleges, American Pharmacy Association, and American Society of Health Systems Pharmacists lists or similar communication portals for health professionals.

**Further needs identified:**

- Profiles (potentially by SAMHSA) of successful, reproducible models of delivering buprenorphine treatment
- Specific formal trainings on implementation of buprenorphine treatment including developing a business plan, setting up an office, and meeting federal or other requirements
- Evaluation of current training practices to find out why physicians are not activating their DATA 2000 waivers and who is signing up for what kind of training

## **4. Buprenorphine for an Opioid Use Disorder in Special Populations**

**Presenters**

- Robert Schwartz: *Buprenorphine Treatment in the Criminal Justice System*
- Michelle Lofwall: *The State of Practice for Special Populations*

**Key Points of Presentations****Findings from five studies on buprenorphine treatment in the criminal justice system:**

- Buprenorphine can be used for detoxification in jails or prisons.
- Initiating buprenorphine maintenance has potential as a prerelease strategy for reentering inmates to reduce recidivism, relapse, and death from overdose.
- Close observation of buprenorphine dosage and linkage to follow-up are required to prevent diversion and optimize outcomes.
- Buprenorphine treatment is as effective for individuals on parole or probation as it is for those not under legal supervision.

**Issues related to buprenorphine treatment in the criminal justice system:**

- Close observation is required to prevent diversion in prison settings.
- For many medical conditions, inmates are discharged from prison on medication, but for addiction, individuals are discharged without pharmacotherapy for this condition.
- Close coordination is needed between the medical and public health community and the criminal justice system so that understanding and acceptance of MAT can be increased and outcomes for patients can be improved.

- The gap in insurance coverage between release from detention and restoration of Medicaid needs to be eliminated.
- The companies that run U.S. prisons and those contracted to provide medical treatment to prisoners should partner with government agencies and other stakeholders to develop and implement MAT to reduce recidivism.
- Litigation on parity can be expected to impact the availability of MAT in correctional settings.

**The state of practice for special populations:**

- Special populations have characteristics related to age, environment, current medical conditions, or current pharmacotherapies complicating substance use. These characteristics produce potential treatment challenges and/or unique treatment needs.
- Treatment access means getting quality individualized treatment to the patients who need treatment where and when they need it and being able to adjust the level of care as appropriate.
- Multiple factors can impact the likelihood that special populations will receive successful treatment such as:
  - Access to telehealth and mobile treatment
  - Parity and adequate provider reimbursement
  - Increased use of collaborative care models such as by involving pharmacies
  - Continuous adjustment of care to meet increased, decreased, or changing needs
  - Treatment guidelines and expectations that can be tempered by flexibility and are based on clinical judgment and experience level
  - Improved education for students in healthcare professions.

**Strategies suggested:**

- Standardize and promote telemedicine.
- Promote MAT for women dependent on opioids to improve pregnancy outcomes.
- Review evidence regarding use of buprenorphine/naloxone in pregnant women.
- Provide guidance in addressing co-occurring disorders.
- Compel parity in access to and treatment with MAT.

**Key Conclusions of Work Group****Strategies suggested for treatment in special populations (including criminal justice):**

- Use a patient-centered approach that allows flexibility in scheduling counseling and office appointments.
- Educate drug court judges, criminal justice system workers, and human services personnel about addiction and MAT.
- Encourage a collaborative and coordinated approach to caring for patients who require specialized treatment or experience social inequities or cultural differences.
- Train and encourage physicians and medical students throughout medical specialties to accept responsibility to care for patients with OUD and any other SUD.

- Decrease burden of treatment for special populations by eliminating barriers imposed by payers (e.g., fail-first, prior authorization) and mandated practices (e.g., specific types, schedules, amounts of behavioral interventions).
- Develop patient-centered models specific to special populations.
- Provide community education about SUD and MAT, such as is done via BeeHIVE or other existing community education and treatment programs.

## 5. Addressing Health Systems and Reimbursement

### Presenters

- Kimberly Jeffries Leonard: *Affordable Care Act and Mental Health Parity: The Playing Field*
- C. Rolly Sullivan: *Effective Care Delivery*

### Key Points of Presentations

#### ACA and Mental Health Parity and Addiction Equity Act (MHPAEA):

- These two acts, in early implementation, are transforming practice and reimbursement for OUD treatment and buprenorphine MAT:
  - State-selected Medicaid expansion and marketplace exchange plans are extending new insurance coverage to millions of Americans.
  - Medicaid expansion mandates new and/or improved benefits for treatment of OUD, including medically necessary buprenorphine; many people who need buprenorphine-based MAT but could not previously afford it may now seek it.
- ACA framework includes:
  - Ten essential health benefits and MHPAEA
  - Expanded insurance coverage and treatment options in primary care as well as specialty settings
  - Incentives for integrated, comprehensive care
  - Improved reimbursement policies based on quality of care and client outcomes, not fee-for-service parameters
  - Pain-related measures and support.
- Physicians will soon face restructuring of compensation and reimbursement policies that include:
  - New payment options for OUD treatment in primary care and specialty settings
  - Financial incentives for integrated care
  - Reimbursement linked to quality of care and outcome measures rather than fee-for-service-based formulas.
- Health systems should be prepared to:
  - Develop a more comprehensive and integrated healthcare delivery environment, which includes routine SUD screening and treatment



- Be aware of the pain–OUD connection and well informed of the best practices in pain management
- Offer a multidisciplinary, interprofessional team approach not only to enhance patient outcomes but also to decrease the administrative overhead and compliance burden and to share resources, infrastructure, and networking capabilities
- Expand clinical support systems, interoperable electronic health records, and other health information technology
- Directly address SUD to improve client outcomes, reduce unnecessary and/or suboptimal service use, and address competing treatment priorities and contraindications (results that can help shape reimbursement policies by removing arbitrary barriers to buprenorphine MAT reimbursement).

**Buprenorphine clinic of West Virginia University—a clinical model of integrated care:**

- Guiding principles of the clinic, based in the Department of Psychiatry, include:
  - Medication alone is not enough.
  - All patients need medical and psychoeducational treatment, so these visits should always be tied together:
    - Medical group (30 minutes)
    - Psychoeducational group (60 minutes)
    - Random urine drug screen onsite that includes buprenorphine
    - 12-step meeting list review
  - Structure should be provided, being mindful of cost/reimbursement.
  - Attendance at outside 12-step programs should be required.
  - Goal is abstinence from alcohol and drugs.
- Patient visit schedule is adjusted according to time in treatment and response to interventions.
- Clinic activities include:
  - Intakes are done by social work faculty, staff, and students; buprenorphine is given at intake if possible.
  - Forty groups per week provide both medication and psychoeducation (basic, intermediate, and advanced levels per patient needs).
  - Pregnancy clinic serves 35 women.
  - Three telemedicine buprenorphine clinics per week operate for patients located in remote sites.
  - Case manager is essential to track details in managing 400 patients.
- Sustainable reimbursement model:
  - Sufficient reimbursement achieved by billing for individual physician office visits (for each group member), for each individual in behavioral group therapy, and for individual urine drug screens
  - Basic psychiatric codes used to bill for these services



**Needs and other issues identified in large group discussion:**

- Some physicians are facing annual limits on urine drug screening/testing set by insurance companies.
- Some SAMHSA National Outcome Measures need to be revised for MAT, particularly those related to discharge.
- MAT-specific National Quality Forum measures are needed.
- Funding by CMS or other federal sources should not pay for non-evidence-informed care.
- Healthcare Common Procedure Coding System codes are needed to bill for buprenorphine services (distinct from those for methadone).
- Specialists certified by American Board of Addiction Medicine need codes to be able to bill for their addiction treatment services.
- A time and motion study and a practice survey need to be conducted to increase reimbursement for current procedural terminology codes related to addiction medicine services.
- Policymakers, professional organizations, and other stakeholders should develop and cultivate direct relationships with state Medicaid directors and/or governors who can help improve behavioral and addiction medicine benefits under the ACA, including modifications to include payment for treatment of OUD as a chronic medical condition.
- Commercial insurance companies could incentivize patients to seek buprenorphine MAT for opioid addiction similar to how they have incentivized quitting smoking and reducing weight.
- Healthcare providers and provider organizations should promote SAMHSA's prescriber clinical support systems, [www.opioidprescribing.com](http://www.opioidprescribing.com), NIDAMED, and other high-quality training and educational resources.

**Key Conclusions of Work Group****Strategies to address health systems and reimbursement:**

- Conduct a media campaign (SAMHSA, Centers for Disease Control and Prevention, and other federal partners) promoting the message that opioid addiction is a public health crisis and that it is a treatable disease.
- Partner with private organizations to promote MAT and public health messaging.
- Encourage U.S. Department of Health and Human Services (HHS), CMS, and other federal agencies to meet with others in high-level, decision-making roles (including the National Association of State Medical Directors, the National Association of Insurance Commissioners) to promote the understanding that the standard of care for opioid addiction is MAT.
- Encourage participation from patients, their families, and communities.
- Involve resident physician and student organizations (e.g., Doctors for America) and house staff organizations at hospitals (e.g., house staff council).
- Address the needs identified in the large group discussion, summarized earlier in this report.

## GUEST SPEAKERS' PRESENTATIONS

The information and perspectives presented by these speakers helped to set the tone of the event and complemented and supplemented the presentations on the five major topics in the agenda. Key points made in their presentations are summarized below.

### **Wilson M. Compton—Welcome (Day 1)**

Dr. Compton, Deputy Director of NIDA, opened the Summit on Day 1 with a review of the crisis in access to treatment for opioid addiction in this country and the need for specific plans to reduce the morbidity and mortality associated with opioid addiction.

#### **Purpose of this Summit:**

- There is a crisis in access to treatment for opioid addiction in the United States.
- We have developed effective treatments, but why aren't they more widely used, and why is there bias within the treatment system against MAT?
- The goal of this Summit is to address these issues and identify strategies to reduce the morbidity and mortality associated with opioid addiction.

### **Michael P. Botticelli—Opening Remarks (Day 1)**

Mr. Botticelli, Acting Director, Office of National Drug Control Policy (ONDCP), gave opening remarks detailing the four pillars of the 2011 ONDCP prescription drug abuse plan, followed by a reminder that the FQHCs and health centers within the U.S. Departments of Defense and Veterans Affairs offer rich opportunities for integration of care. He emphasized the need to make MAT the standard of care and to identify models of care that use MAT in primary care settings.

#### **The four pillars of the 2011 ONDCP prescription drug abuse plan:**

- Education, including improved education for physicians about safe prescribing
- Monitoring, through PDMPs in every state that can share data
- Proper disposal of unused drugs
- Enforcement, to reduce the prevalence of pill mills and doctor shopping and to reduce diversion

#### **Why this Summit:**

- Overdoses driven by prescription drug abuse are now the number one cause of unintentional death, and heroin-related deaths have increased as well.
- Patients with OUD can be successfully treated with MAT using buprenorphine and other medications approved by FDA.
- ONDCP has convened federal agency representatives to review government programs, policies, and administrative authorities; identify barriers to MAT; explore ways to increase MAT for OUDs; and coordinate federal agencies' efforts. Some states (e.g., Massachusetts, Vermont, West Virginia) have also sought to expand access to MAT.

- Nationwide, primary care centers—including FQHCs and health centers within the U.S. Departments of Defense and Veterans Affairs—offer very rich opportunities for integration of SUD treatment, particularly MAT.
- We need to look at how we use primary care infrastructure for not only SUD treatment but particularly MAT and identify models around the country.

## **Melinda Campopiano von Klimo—Addressing Hurdles and Looking Forward**

The meeting was opened and its purpose described by Dr. Campopiano von Klimo.

### **Opening Remarks:**

- Those seated around the table were invited specifically for their expertise and experience; seated in the back are representatives of federal agencies and partner organizations (the latter thanked for taking a back seat temporarily).
- We must not get bogged down in considering existing policies. Rather, we are here to talk about strategies and solutions that work in caring for patients; designing, operating, and sustaining programs; supporting recovery; training providers; promoting the adoption of buprenorphine; and ensuring the safety of the public.

## **Kimberly Jeffries Leonard—Welcome and Opening (Day 2)**

On Day 2, Dr. Leonard, Deputy Director of CSAT, SAMHSA, reviewed the discussions held on Day 1 and encouraged the participants to identify actionable items for future development.

### **On Day 1, participants considered and discussed many things:**

- The need for ongoing education for physicians, residents, and other healthcare providers
- The need for prescribers to obtain and use DATA 2000 waivers to bring vital MAT to those in need
- Ways that we as members of a professional community must address barriers to the establishment and integration of buprenorphine treatment services
- Interprofessionalism and team-based approaches to practice and to education
- Models of buprenorphine prescribing and financial viability, particularly Vermont's hub-and-spoke model, ECHO's telehealth model in New Mexico, and a nurse-managed FQHC model in Massachusetts
- Agent-based modeling and its utility in studying variables and influencing capacity and quality of care through statistical analysis

### **On Day 2's agenda:**

- Discuss the ACA and parity.
- Explore a clinical model of integrated care in place in West Virginia.
- Hear from SAMHSA Administrator Pamela Hyde and Senator Carl Levin.
- Continue dynamic and productive discussions collectively and in small work groups.

**Participants and federal agencies work in partnership:**

- Participants' energy and commitment throughout this Summit have been inspiring, and SAMHSA and its federal partners rely on participants' experience, insights, and recommendations to inform programs and policies.
- SAMHSA looks forward to continuing to work with participants to translate a shared vision into reality.

**Pamela S. Hyde—Introduction of Senator Carl Levin**

SAMHSA Administrator Pamela S. Hyde introduced Senator Carl Levin, documenting his years of devotion to the issue of opioid treatment.

**Distinguished longtime public servant:**

- First elected to the U.S. Senate in 1978; chairs the Senate Committee on Armed Services, the Permanent Subcommittee on Investigations, and Governmental Affairs Committee
- Over two decades has supported efforts to develop more effective means of combating drug abuse and addiction and ensuring access to care for those struggling with SUDs

**Strong advocate for MAT with buprenorphine for people with OUD:**

- Coauthored DATA 2000, which permits buprenorphine to be prescribed in physicians' offices
- Cosponsored 2006 amendment to DATA 2000 that made further changes enabling office-based prescribing
- Continues to examine these issues and consider how to effect wider adoption
- Has decided to retire in 2015

**Senator Carl Levin—Remarks**

After briefly reviewing his vision for buprenorphine treatment in the future, Senator Levin shared with the group a checklist of items that he would like to see addressed in the short term.

**Perspective to share at the end of his Senate career:**

- Despite the ongoing OUD epidemic, of the 625,000 physicians in the country, only 25,000 have a DATA 2000 waiver; only about 2 percent, or 4 percent of U.S. primary care physicians, and less than a third of the addiction physicians are certified.
- Advocates for MAT using buprenorphine (e.g., those here) need to triple their efforts.

**Checklist of what Senator Levin believes needs to be done to expand access to buprenorphine/naloxone and increase the number of certified physicians:**

- Optimize availability under the ACA.
- End the 100-patient limit, either administratively (by regulations) or by legislation.
- Involve all 1,300 community health centers, operating at more than 9,200 service delivery sites.

- Involve medical schools.
- Utilize telemedicine.
- Allow trained nurse practitioners to prescribe.
- Involve the National Health Service Corps.
- Attack bureaucratic hurdles.
- Educate DEA.
- Involve the NGA.
- Inform drug courts.
- Support a White House forum.

## **Elinore McCance-Katz—Closing Remarks**

Dr. McCance-Katz, Chief Medical Officer, SAMHSA, closed the Summit by thanking all Summit Steering Committee members and the Summit participants and sharing her expectations about future developments.

### **Thanks and next steps:**

- Thanks to participants for contributing time and energy to make this a dynamic, productive Summit.
- Thanks to Steering Committee, NIDA, and all planners.
- Proceedings will be available for use by all here and federal officials considering policy decisions in this area.
- SAMHSA hopes to draw further on work groups' expertise in the future and provide resources to the field with regard to adoption and implementation of MAT with buprenorphine.

## **SUMMARY OF ACTIONABLE ITEMS**

### **MAT Needs to Be a First-option Therapy for Patients With OUD**

- Recommend that MAT be offered at all FQHCs and Community Mental Health Centers and that SUD treatment programs offer some form of MAT as a requirement to receive federal or state dollars via grants or contracts.
- Work with CMS and state Medicaid directors to improve Medicaid coverage and reimbursement options including full adoption of existing OUD-related codes and the development of additional billing codes where needed (e.g., in OTPs).
- Expand and make reimbursable telemedicine for both the delivery of expert consultation and the treating professional's time spent in clinical consultation for complex cases.
- Develop a media campaign with SAMHSA and NIDA to promote MAT as the standard of care for opioid treatment and address bias against the disease of addiction and MAT.
- Use federal and professional organization channels to disseminate the message; include consumers as well as policymakers in developing the campaign.

**Ensure High-quality Care Along With Systematic Expansion**

- Promote buprenorphine in combination with naloxone as the preferred formulation, with a limited role for the buprenorphine monoproduct.
- Provide guidance to the field about the range of possible effective doses, and the lack of evidence for added benefit of more than 24 mg daily, to reduce habitual overprescribing that may be fueling diversion.
- Reduce diversion via the use of prescription drug monitoring or other health information exchanges and rely less on DEA inspections.
- Consider how to customize DATA 2000 waiver training for specific subsets of prescribers (e.g., psychiatrists, internists, family physicians) to increase the likelihood that providers will ultimately make use of their waivers.
- Conduct an evaluation of current training systems and barriers to adoption to determine why so few physicians request DATA 2000 waivers or fail to use them fully or at all.
- Improve knowledge and skill acquisition about substance use in general and MAT in particular across the professional life span of healthcare providers beginning with pre-professional education, and continuing through professional school, clinical training, and continuing professional education.
- Partner with professional societies and organizations. CMS, which pays for resident physician training, could play an important role in such a process.

**Promote Optimal Models of Care Delivery and Address Barriers to Their Widespread Adoption**

- Produce a detailed review of current proven models of care delivery, with accompanying business plans, published in a report or paper as an outcome of this Summit.
- Evaluate DATA 2000 and other regulations or requirements imposed on buprenorphine by insurers, government entities, and others for (1) effectiveness in achieving their intended purpose, such as safe and appropriate prescribing and the health and safety of the public, (2) unintended negative impact on prescriber willingness to provide buprenorphine treatment, or (3) access to treatment for persons with OUD.
- Look for areas where adverse consequences may be unintended such as interpreting the patient limit to encompass short-term, cross-coverage arrangements.
- Make an organized effort to enhance the understanding and acceptance of MAT by criminal justice and law enforcement agencies such as DEA and drug courts.

## EVALUATION

Summit participants left the meeting encouraged about the prospects for advancing and expanding buprenorphine treatment. The majority of survey respondents were very satisfied or satisfied with the choice of meeting topics and logistics. Respondents particularly enjoyed the opportunities to network and discuss issues, but would have appreciated even more time working in small groups, more diverse representation among the invited guests and speakers, and more patient involvement at the sessions.

## **APPENDIX A: SUMMIT STEERING COMMITTEE**



## **SUMMIT STEERING COMMITTEE**

- Anton C. Bizzell, M.D., President, The Bizzell Group, LLC
- Maureen Boyle, Ph.D., Science Policy Branch, NIDA/National Institutes of Health (NIH)
- Melinda Campopiano von Klimo, M.D., CSAT/SAMHSA
- Jessica Cotto, M.P.H., Office of Science Policy and Communications, NIDA/NIH
- Yvonne Davis, M.P.H., Indian Health Service/HHS
- Marc Fishman, M.D., Maryland Treatment Centers
- Sidney Hairston, CSAT/SAMHSA
- Pamela Horn, M.D., FDA/HHS
- LCDR Brandon T. Johnson, M.B.A., CSAT/SAMHSA
- Daniel Kivlahan, Ph.D., Addictive Disorders Mental Health Services, Veterans Health Administration
- Margaret Kotz, D.O., Addiction Recovery Services, University Hospitals of Cleveland, Case Medical Center
- Robert Lubran, M.S., M.P.A., CSAT/SAMHSA
- Laura Makaroff, D.O., Office of Quality and Data, Health Resources and Services Administration (HRSA)/HHS
- Marcella Ronyak, Indian Health Service/HHS
- June S. Sivilli, M.A., ONDCP/Executive Office of the President (EOP)
- Ben Wheat, M.D., Federal Bureau of Prisons

## **APPENDIX B: PARTICIPANTS AND OBSERVERS**

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## PARTICIPANTS

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## SMALL WORK GROUP PARTICIPANT LIST

### Small Work Group 1: Access to Buprenorphine: Patient Capacity and Quality Care

**Moderator:** C. “Rolly” Sullivan  
**Participants:** Jeffrey Baxter, Marc Fishman, Anthony Folland, Pamela Horn, Margaret Kotz, Michelle Lofwall, Mark A. McGrail, Susan Robilotto, Wayne Wakeland  
**Observers:** Robert DeLuca, Timothy Lepak, Nicholas Reuter

### Small Work Group 2: Access to Buprenorphine: Workforce Considerations

**Moderator:** Miriam Komaromy  
**Participants:** Steven Dettwyler, Adam Gordon, Brandon T. Johnson, Colleen LaBelle, Alexandra Nielsen, Alicia Swenson O'Brien, Patricia Pade, Andrew J. Saxon  
**Observers:** Rick Harwood, Kathy McNamara

### Small Work Group 3: The Role of Provider Training in Improving Access

**Moderator:** Stephen Wyatt  
**Participants:** James Finch, Reema Mehta, Wilma Townsend  
**Observers:** Anthony Tommasello, Nina Vidmer

### Small Work Group 4: Buprenorphine for an Opioid Use Disorder in Special Populations

**Moderator:** Marjorie Meyer  
**Participants:** Margaret Chisolm, Charles T. Ellis, Todd Korthuis, Sharon Levy, Nancy E. Paull, Robert P. Schwartz  
**Observer:** Rolley “Ed” Johnson

### Small Work Group 5: Addressing Health Systems and Reimbursement

**Moderator:** Kelly J. Clark  
**Participants:** Maureen Boyle, Joel M. Dubenitz, Daniel Hindman, Mark Kraus, Todd Molfenter, Yngvild Olsen, June S. Sivilli, Rachel Skeete, George Woody  
**Observers:** David Byram, Penny S. Mills

## **APPENDIX C: AGENDAS FOR GENERAL SESSIONS AND WORK GROUPS**



**AGENDA FOR GENERAL SESSIONS*****Monday, September 22, 2014***

- 8:00–8:55      Registration
- 8:55–9:00      Welcome: Wilson M. Compton
- 9:00–9:30      Opening Remarks: Michael P. Botticelli
- 9:30–9:40      Addressing Hurdles and Looking Forward: Melinda Campopiano von Klimo
- 9:40–10:10    **Access to Buprenorphine: Patient Capacity and Quality Care**
- Miriam Komaromy: *Provider-Level Barriers to Buprenorphine Adoption*
  - Jinhee J. Lee: *DEA ARCOS Trend Analysis-NTP Buprenorphine Purchases*
  - Christopher M. Jones: *Trends in Need vs. Capacity for Opioid Agonist Therapy*
  - Moderator: Marc Fishman
- 10:10–11:10   Participant Discussion
- Moderator: Marc Fishman
- 11:10–11:25   Break
- 11:25–11:55   **The Role of Provider Training in Improving Access**
- Andrew J. Saxon: *Impact of Current Training Requirements*
  - Stephen Wyatt: *Training in Support of Adoption and Implementation*
  - Moderator: Maureen Boyle
- 11:55–12:55   Participant Discussion
- Moderator: Maureen Boyle
- 12:55–1:30    Lunch
- 1:30–2:00      **Access to Buprenorphine: Workforce Considerations**
- Colleen LaBelle: *Integrated Approach to Treatment Expansion*
  - Wayne Wakeland: *Buprenorphine Treatment Capacity: A Descriptive Agent-Based Model*
  - Moderator: Jeff Baxter
-

- 2:00–3:00 Participant Discussion
- *Moderator: Jeff Baxter*
- 3:00–3:15 Break
- 3:15–3:45 **Buprenorphine for an Opioid Use Disorder in Special Populations**
- Robert P. Schwartz: *Buprenorphine Treatment in the Criminal Justice System*
  - Michelle Lofwall: *The State of Practice for Special Populations*
  - *Moderator: Margaret Chisolm*
- 3:45–4:45 Participant Discussion
- *Moderator: Margaret Chisolm*
- 4:45–5:00 Wrap-Up Day 1: Melinda Campopiano von Klimo

***Tuesday, September 23, 2014***

- 8:00–8:45 Day 2 Check-In
- 8:45–9:00 Welcome and Opening of Day 2: Kimberly Jeffries Leonard
- 9:00–9:30 **Addressing Health Systems and Reimbursement**
- Kimberly Jeffries Leonard: *Affordable Care Act and Mental Health Parity: The Playing Field*
  - C. “Rolly” Sullivan: *Effective Care Delivery*
  - *Moderator: Elinore McCance-Katz*
- 9:30–10:25 Participant Discussion
- *Moderator: Elinore McCance-Katz*
- 10:25–10:30 Introduction of Senator Carl Levin by Pamela S. Hyde, Administrator, SAMHSA
- 10:30–10:45 Remarks From Senator Carl Levin
- 10:45–11:00 Break
- 11:00–12:30 Small Group Work and Lunch
- 12:30–1:45 Small Group Report-Out
- *Moderator: Melinda Campopiano von Klimo*
- 1:45–2:00 Closing Remarks: Elinore McCance-Katz

## **WORK GROUP SESSIONS: AGENDA AND DISCUSSION QUESTIONS**

### **Work Group Objectives**

At the summit, the work groups will:

- Use the questions provided to generate discussion.
- Identify key points regarding buprenorphine within each group's assigned topic area.

Key points may be:

- Concise problem statements
- Strategies to achieve specific benefits
- Metrics and analytic strategies to assess the scope of problems or the impact of possible solutions

In the future, the work groups may be asked to:

- Continue discussion of key issues online.
- Meet at upcoming small conferences (one of the five conferences scheduled in 2014–2015).
- Initiate work on implementation and skill acquisition (related to key summit topic points).
- Review reports, including guidance on implementation and skill acquisition.

### **Work Group Agenda**

- Introductions: Ask work group participants to spend 1 to 2 minutes introducing themselves and describing their research or clinical interests.
- Review work group specific questions (see below) and explain that a note taker has been assigned to capture the discussion.
- Identify key points to be discussed in the reporting-out session.
- If time permits, review the 2014 Buprenorphine Summit Bibliography and determine whether there are any pertinent references missing.

### **Questions by Work Group Session**

#### Work Group #1: Access to Buprenorphine: Patient Capacity and Quality Care

- What may be the impact of different formulations of buprenorphine on patient access and quality of care?
- What strategies are most likely to promote the adoption of buprenorphine by more providers?
- What is the best way to address diversion and accidental exposure due to expanded access to buprenorphine?
- How might technology best be used to improve quality of care as access is expanded to buprenorphine?

Work Group #2: Access to Buprenorphine: Workforce Considerations

- What may be the impact of different formulations of buprenorphine on workforce considerations?
- What strategies are most likely to promote the adoption of buprenorphine by more providers?
- How will integration of primary care, behavioral health, and addiction treatment impact workforce considerations?
- How should technology be used to support workforce considerations? How can technology support quality care?
- How do workforce considerations impact the risk of accidental exposure to buprenorphine and diversion?

Work Group #3: The Role of Provider Training in Improving Access

- What training is needed to support adoption of buprenorphine by those who obtain DATA 2000 waivers?
- What public or professional education is needed to increase willingness to provide, and interest in providing, buprenorphine among those who have not sought training?
- How can provider training improve the quality of care delivered to patients receiving buprenorphine?
- What training strategies can be used to reduce diversion and prevent accidental exposure?

Work Group #4: Buprenorphine for an Opioid Use Disorder in Special Populations

- What public or professional education is needed to expand access to buprenorphine for high-risk and high-benefit populations such as individuals involved in the criminal justice system, pregnant women, military service members, and veterans?
- What may be the impact of different formulations of buprenorphine on access to care for these populations?
- How do issues around diversion impact care of these populations and how can these issues be addressed?
- How can provider training improve access and quality of care delivered to these patient populations?

Work Group #5: Addressing Health Systems and Reimbursement

- What strategies do you suggest to increase provider engagement with third-party payers?
- What public and professional education is needed to increase willingness and interest in providing and supporting buprenorphine services?
- How can provider training support care coordination and engagement with third-party payers?
- What is the impact of diversion and accidental exposure on health system support?

### General Crosscutting Issues:

- Elicit discussion on crosscutting topics such as technology, diversion, implementation, integration, quality, parity, health disparities, pediatric and other accidental exposures, formulations of buprenorphine, limitations imposed at the state level, psychosocial interventions, and use of buprenorphine for pain.

## **APPENDIX D: TREATMENT MODELS**

## TREATMENT MODELS DISCUSSED AT THE SUMMIT

Over the course of the Summit, several treatment models were discussed. Some of the models are further along in their development than others. The list of treatment models in this appendix is provided as a resource. Relevant links are given where available.

Clinical model of integrated care (West Virginia, University of West Virginia Medical School)

- Online information currently unavailable

FQHCs (Nationwide, such as SSTAR, Fall River, Massachusetts)—Centers get enhanced Medicaid reimbursement, and Medicare deductibles are waived

- <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network/MLN/MLNProducts/downloads/fqhcfactsheet.pdf>
- General FQHC information:
  - <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html>
  - <http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers/FQHC-Center.html>

HIV BeeHIVE demonstration project (HRSA special project)

- [http://www.hab.hrsa.gov/about/hab/files/hab\\_spns\\_buprenorphine\\_monograph.pdf](http://www.hab.hrsa.gov/about/hab/files/hab_spns_buprenorphine_monograph.pdf)
- <https://www.careacttarget.org/library/beehive-buprenorphine-program-tools>

Hub-and-spoke model (Vermont)

- <http://www.leg.state.vt.us/reports/2013ExternalReports/285154.pdf>
- <http://www.gmcboard.vermont.gov/sites/gmcboard/files/Hub%26Spoke032014.pdf>
- <https://www.pcpcc.org/initiative/vermont-hub-and-spokes-health-homes>

Missouri model (cross-agency care coordination)

- Online information currently unavailable

Nurse care manager (NCM) model (Massachusetts, Boston Medical Center—Collaborative care model)

- [http://www.pcssmat.org/wp-content/uploads/2014/10/PCSSMAT-Online-Module-Role-of\\_FQHC-in-OBOT-Colleen-Labelle-AMERSA.pdf](http://www.pcssmat.org/wp-content/uploads/2014/10/PCSSMAT-Online-Module-Role-of_FQHC-in-OBOT-Colleen-Labelle-AMERSA.pdf)

Patient and partner model (Maryland, Johns Hopkins Medical Center—Used in pediatrics and with adolescents)

- Online information currently unavailable

Patient-centered model (Maryland, Johns Hopkins Medical Center—Dissemination and connection of specialty care providers [maternity, special populations to primary care])

- Online information currently unavailable

Peer-mentoring model (PCSS—a SAMHSA-funded cooperative agreement)

- <http://www.pcass-o.org>

Project ECHO (New Mexico—Telehealth for physician consultations)

- <http://echo.unm.edu>

Rural programs with minimal staffing (Montana, significant Native American representation)

- Online information currently unavailable



## **APPENDIX E: BUPRENORPHINE BIBLIOGRAPHY**

# 2014 Buprenorphine Summit Bibliography

September 22-23, 2014

**SAMHSA Building**  
1 Choke Cherry Road  
Rockville, Maryland

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## INTRODUCTION

This bibliography contains citations for more than 400 articles, books, chapters, and other materials published since 2007. It is organized into the following sections:

- Pharmacology of Buprenorphine
- Treatment with Buprenorphine
- Buprenorphine in the Treatment of Special Populations
- Preventing and Responding to Buprenorphine Diversion and Abuse
- Access to Treatment with Buprenorphine

To the extent possible, bibliographic entries appear under only one heading. The criterion for including an article in the bibliography was that it was published in a peer-reviewed journal within the last 7 years. The following databases were searched: Pubmed/Medline, PsycINFO, EBSCO/Medline, Scopus, Embase, Web of Science, and Health Policy Reference Center.

Articles submitted to the portal library in the weeks prior to the conference appear as the last section of the bibliography.

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**Contributors:** The preface and bibliography were prepared by JBS International, Inc., staff members and consultants, including Project Director Bonnie B. Wilford, M.S., Medical Consultant Gwen Solan Littman, M.D., and Research Librarian Jeffrey L. Vender, M.L.I.S., in support of the SAMHSA–NIDA Buprenorphine Summit held September 22–23, 2014.

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- Pharmacology
- Efficacy and safety
- Side effects and adverse events
- Drug interactions
- New formulations
- Novel indications

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- Clinical protocols and evidence-based practices
- Patient assessment, selection, and education
- Management of withdrawal
- Induction and stabilization
- Adjunctive therapies
- Patient monitoring
- Treatment adherence, compliance, and retention
- Relapse
- Buprenorphine taper
- Treatment outcomes

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## BUPRENORPHINE IN THE TREATMENT OF SPECIAL POPULATIONS

- Pregnant and postpartum women
- Neonates and children
- Adolescents and young adults
- Older adults
- Active duty military and veterans
- Health care professionals
- Persons
- Persons in correctional settings and recently incarcerated individuals
- Persons engaged in nonmedical use of multiple substances
- Persons with co-occurring substance use and mental disorders
- Persons with co-occurring substance use and medical disorders

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## ADOLESCENTS AND YOUNG ADULTS

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## PREVENTING AND RESPONDING TO BUPRENORPHINE DIVERSION AND ABUSE

- Characteristics and consequences of buprenorphine diversion and abuse
- Prevention and/or intervention for buprenorphine diversion and abuse

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## ACCESS TO TREATMENT WITH BUPRENORPHINE

- Federal regulations
- State medical board policies and legislative actions
- Costs and cost-effectiveness of treatment with buprenorphine
- Health insurance coverage and financing issues
- Factors in physicians' acquisition of DATA 2000 waivers and prescribing of buprenorphine
- Facilitators of, and barriers to, use of buprenorphine in primary care
- Innovative approaches and model programs
- Strategies to address workforce issues

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## **STRATEGIES TO ADDRESS WORKFORCE ISSUES**

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## ADDITIONAL ARTICLES

This section of the bibliography contains additional articles submitted to the portal library in the weeks prior to the conference by participants, speakers and observers.

### ARTICLES SUBMITTED BY PARTICIPANTS

#### ACCESS TO BUPRENORPHINE

Clark RE, Samnaliev M, Baxter JD, Leung GY. The evidence doesn't justify steps by state Medicaid programs to restrict opioid addiction treatment with buprenorphine. *Health Aff.* 2011; 30(8):1425-1433.

Gunderson EW, Fiellen DA, Levin FR, Sullivan LE, Kleber HD. Evaluation of a combined online and in person training in the use of buprenorphine. *Subst Abus.* 2006; 27(3):39-45.

#### DIVERSION AND ABUSE

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#### SPECIAL POPULATIONS

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### ARTICLES SUBMITTED BY SPEAKERS AND ORGANIZERS

#### IMPROVING ACCESS TO BUPRENORPHINE

Clark RE, Samnaliev M, Baxter JD, Leung GY. The evidence doesn't justify steps by state Medicaid programs to restrict opioid addiction treatment with buprenorphine. *Health Aff.* 2011; 30(8):1425-1433.

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