Adoption of Buprenorphine in Two Integrated Health Plans

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Buprenorphine

- Drug Abuse Treatment Act of 2000
  - Authorized waivers for qualified physicians
  - Caseload = 30 or less patients per group (i.e., a health plan)
- FDA approved October 2002
- DATA 2000 amended: caseload = 30 or less patients per physician (December 2005)
- DATA 2000 amended: caseload = 100 or less patients per physician (January 2007)
Assessed Implementation of Buprenorphine

- Tracked number and percent of opioid dependent individuals receiving buprenorphine prescriptions (2002 – 2008)
  - Data from two integrated health plans
- Interviewed 97 clinicians and clinician administrators
  - Addiction treatment, primary care, psychiatry, surgery, obstetrics & gynecology and inpatient settings
  - 5 interviewed at two points in time
  - Interviewed between July 2006 and February 2009
- Interviews probed four dimensions (Thomas, et al., 2003)
  - Clinician attitudes, organizational policies
  - System influences, characteristics of the technology
Qualitative Methods

- Interviews transcribed and coded by trained coders
- Investigators and coders reviewed transcripts and identified key words and phrases describing content
  - Key words and phrases were consolidated for draft coding scheme
  - Tested, refined and applied coding scheme
- Coders met weekly to review the same section of coded text and resolve discrepancies
- Queries retrieved text coded with single or multiple codes
- Investigators and coders reviewed query text and extracted common themes and potentially important ideas
- We also examined text for contradictory examples of themes.
Opioid Dependence and Treatments
Health Plan A

Trends Over Time in Health Plan A

Year
Number of people
People with 2+ opioid dx
Buprenorphine
Methadone
2+ AM Visits
Opioid Dependence and Treatments: Health Plan B

Trends Over Time in Health Plan B

- Number of People with 2+ opioid dx
- Buprenorphine
- 2+ AM Visits

Year

0
500
1000
1500
2000
2500
3000
3500

Number of People

People with 2+ opioid dx
Buprenorphine
2+ AM Visits
Organizational Influences

• No experience with agonist therapy
  • “We didn’t have opioid maintenance. . . . We had to accept the concept of opioid maintenance and then we also had to train to learn to use buprenorphine.

• Experience with buprenorphine
  • [We] were in a clinical trial. . . . That was my first experience with buprenorphine. It was another year before it was [approved] . . . I have been using it ever since.
System Influences: Pharmacy

• It took time and effort to develop systems with pharmacies to ensure they had supplies of the new medication in stock:
  • …when someone would go there [pharmacy]…it had to be special-ordered and it would take 3 to 5 days to get and that was a HUGE, HUGE problem…
  • …it took a lot of emailing and calling and discussion…so that when the doctor sends the prescription over the patient can pick it up.
System Influences: Insurance

- Prior to buprenorphine, some plan administrators were concerned about adverse selection into the health plan because other health plans did not offer methadone.

- When buprenorphine became available, policies about maintenance had to change in order to offer the new treatment.
Technology: Convenient, Effective, Promotes Recovery

- Clinicians were more positive about buprenorphine than methadone because of the clinical environment:
  - I like Suboxone better than methadone. Particularly because of the way that it's prescribed...a lot of patients really don't like methadone clinics and there's things that happen at methadone clinics that aren't always conducive to someone's recovery.

- Many also reported that buprenorphine detoxification was an improvement over prior detoxification protocols:
  - Well, the difference between people who are detoxing on the regular group and the people who are detoxing on the Suboxone seem to be pretty significant as far as their comfort level of detox and their need for ancillary medications
Technology Concerns: Maintenance, Side Effects

- As clinicians who had limited experience with maintenance protocols initially tried detox protocols first but found it did not help most people stay sober.

- This suggesting maintenance approaches, and protocols were transitioned from detox to maintenance.
  - Some [clinicians] started using buprenorphine [for detox] but...[transitioned to maintenance] because they couldn't get people off.

- Clinicians also raised concerns about lack of knowledge about long-term effects of buprenorphine
  - I just think that if you get people on a medication for a long amount of time, we just don't know the long term effects of the medication. So, I get concerned about that.
Technology: Cost

- Rarely did clinicians consider costs of the medication to the health plan when they felt patients needed it.
- Conversely, costs to the patient played a role in treatment recommendations:
  - All three [of my] present patients on buprenorphine [are] very distraught financially, and one is paying COBRA at huge prices … They cannot pay out of pocket for it.
- Some clinicians counseled patients about the costs of addiction vs. the costs of medication:
  - I'm sure it's cheaper than illicit opiates. And if somebody doesn't have a prescription benefit, I encourage them to think about it in terms of risk versus benefit
Patient Attributes: Stability, Commitment

- Clinicians considered various patient attributes when deciding whether or not to recommend buprenorphine:
  - If they’re homeless or somebody that’s at environmental risk, I think we’re going to go first to stabilization as quickly as possible… I think that would…move me faster…to putting them on a maintenance program… I can’t treat people unless they return.

- Of patient attributes, commitment to treatment was important in deciding about recommending buprenorphine detoxification:
  - There needs to be some motivation and there needs to be a demonstration of commitment. … When you set up your superstructure of saying, I will help you with your opiate withdrawal by using this drug, BUT it's coupled with other things. You know, that's what it takes…that qualifies people, pre-qualifies them.
Practitioner Acceptance: A Function of Experience

- Clinicians’ experiences, positive or negative, affected their thinking about recommendations:
  - Although the detox seems a LITTLE easier for them, they seem a LITTLE more comfortable - only about half of them stick around...I think the honeymoon is long over. It’s - it’s not magic. This drug has not made it significantly easier to treat this group of patients.

- Clinicians reported more positive experiences for maintenance than for detoxification:
  - Should they stay on this for the rest of their lives, or should they try to get off of it at some point? And, I’m sort of at the feeling now, it’s just kind of up to them.... But, if you were to ask me that a year ago, I would have given you a different answer. I’m kind of believer now...a lot of people are doing really well who I don’t think would have done well under the old system.
Leadership

- The Chief of the services is very enthusiastic about it [buprenorphine]. I feel free to use it a lot – as much as I can.
Discussion

- Buprenorphine changing treatment for opioid dependence
- Prior experience with buprenorphine and methadone facilitated organizational implementation
- System changes were required
- Convenience and effectiveness promoted implementation
- Concern with maintenance medication, potential unknown side effects and cost of the medication inhibited use
- Patient stability and commitment to change affected willingness to prescribe
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