Practice Strategies to Improve Compliance and Patient Self-Management

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ABSTRACT

BACKGROUND: Failure in treating opioid dependence is costly to the patient, the employer, managed care organizations, and the overall health care system. Opioid dependent patients tend to be less productive at work and in society and utilize a great many health care resources. Optimizing outcomes is essential.

OBJECTIVE: To introduce the benefit of integrated strategies and patient support in the treatment of opioid dependence.

SUMMARY: Health Analytics is currently studying the benefit of HereToHelp, a behavioral support program in which registered nurses or addiction treatment counselors with specialized training in addiction education provide information and encouragement to patients receiving pharmacologic treatment for opioid dependence. A total of 470 physicians in 41 states have been enlisted to participate in this patient support study. The study hypothesis is that patients who receive behavioral support and encouragement will be more compliant with their opioid replacement therapy, leading to better outcomes. Additional treatment strategies are also being developed to minimize the risk of abuse and diversion. Prodrugs and vaccines are also being investigated.

CONCLUSION: A coordinated team approach is essential in treating pain patients and opioid-dependent patients. Offering behavior modification in addition to pharmacotherapy and utilizing strategies such as prescription monitoring programs, pain contracts, and screening are all vital components necessary for positive outcomes.

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Health Analytics is currently conducting a randomized controlled trial to determine the health outcomes effectiveness of buprenorphine medication-assisted therapy (B-MAT) alone and in combination with an adjunct care coach program, HereToHelp. The sample includes patients with a diagnosis of opioid dependence who are new to office-based opioid treatment and are initiating B-MAT.

The care coaching concept is one of patient support. It is a telephonically based adjunct to active therapy. HereToHelp was designed to provide new B-MAT patients with encouragement and to help them resolve problems inherent to early B-MAT treatment. The intervention consists of care coaching (patient support), which starts with an initial telephone contact by a care coach. The care coaches are trained registered nurses or Certified Addictions Counselors (CAC) with specialized training in addiction education. They provide patient education in the areas of addiction, opioid dependence recovery, what to expect from treatment, and encourage patients to engage in counseling in addition to the med check visits they must attend monthly to refill their prescriptions. They provide patient support in terms of appointment reminders and links to other clinical ancillary services that might be appropriate. Care coaches provide telephonic-based encouragement in a series of 8 calls during the first 3 months of buprenorphine-naloxone therapy. The program is structured to provide more frequent calls earlier in treatment, with fewer calls as patients reach the maintenance phase of treatment.

The study hypothesis is that those patients who receive patient support (care coaching) will have improved outcomes compared with those who do not receive patient support. The hypothesis has 2 stages: the first stage hypothesizes that those patients in the patient support program (care coaching program) will have improved compliance with their treatment regimen. It is hypothesized that these patients will remain on buprenorphine/naloxone longer, will have fewer early discontinuations of therapy, and will take their doses more consistently over time. The second stage builds off the first. As patients in the support program will be more compliant with their medication regimen, it is hypothesized that the patient support group will have a reduction in drug dependence symptoms, increased psychosocial health, and decreased unnecessary utilization of costly health care services. They will also improve their productivity in the workplace.

On the Horizon

There are many new treatments and treatment strategies on the horizon for treating opioid dependence and designed to minimize misuse, abuse, and diversion of opioid analgesics.[1,2] A long-acting, injectable form of naltrexone is being studied to be given monthly. It is currently approved for use in alcohol dependence. It is thought that cravings will be controlled by blocking

neurotransmitters in the brain.[1] Lofexidine hydrochloride (an antihypertensive drug similar to clonidine) is an agent that has been in use in the United Kingdom to lessen opioid withdrawal symptoms, and with less risk of hypotension when compared with clonidine.[3] It is currently being evaluated in the United States and may be available in the next 5 years.[1]

Aversive technologies are being utilized to prevent abuse and diversion. Adding opioid antagonists like naloxone to counter opioid effects if tablets are crushed is being considered for many opioids. Some examples include oxycodone immediate release plus naltrexone, oxycodone extended release plus naltrexone, and morphine sulfate plus naltrexone. Other aversion strategies being investigated include adding capsaicin to produce burning, ipecac to induce nausea and vomiting, or bitter-tasting agents to deter patients from misusing opioid analgesics.[2]

Prodrugs that require first-pass metabolism are also in development; formulations of prodrugs would make it more undesirable to misuse or abuse these agents, as the release of drug and effect would be too slow. A prodrug of hydrocodone is currently being evaluated.[2]

An opioid vaccine is being investigated that would theoretically prevent opioids from ever reaching the user's brain.[1] Similar studies are already being tested in humans for a nicotine vaccine.[1] Naltrexone implants that provide 8 to 10 weeks of opioid blockade are currently being studied in Russia and Norway.[3] Long-term delivery of buprenorphine is also under investigation. An implant that is reported to deliver stable levels of buprenorphine over 6 months is currently being studied in humans.[3]

The potential of NMDA (N-methyl-D-aspartate) receptor antagonists are being studied in rodents for preventing tolerance and dependence in rodents. Agents such as memantine, ketamine, phencyclidine, and dextromethorphan may be helpful in reducing cravings and could be used as an adjunct to other regimens used in treating opioid dependence.[3]

Because corticotrophin-releasing hormone (CRH) is thought to be involved in response to stress and its action as a central nervous system modulator, researchers are looking into synthesizing selective CRH receptor antagonists to be used in the treatment of substance abuse, anxiety, and depression. It is believed that CRH antagonists can block conditioned aversion responses and attenuate withdrawal from opioids.[3]

In order to address abuse and mismanagement of pain, novel strategies are being developed. Opioid diversion is a major problem. Prescription monitoring programs (PMPs) are being used to monitor and report on the utilization of controlled substances in many states. However, there are limitations due to different programs being used in each state that don't interface with each other. Also, while PMPs can be useful tools, they may also be a barrier to care for some patients. They are often used to help law enforcement agencies to identify doctors who they feel are overprescribing and patients who are "doctor shoppers." This creates a barrier for some physicians who are worried about legal ramifications when trying to manage difficult pain cases.[2]

Conclusion

A coordinated approach to pain management is necessary. MCOs should evaluate difficult cases in an objective fashion, not just based on the costs generated by a member. Criteria should be based on whether the resources the patient is using are appropriate. Are patients being evaluated by a group of pain management specialists? If so, are they providing appropriate recommendations?

What is lacking? From the physicians' perspective, MCOs and PBMs provide physicians with letters regarding members who are getting high doses of a prescription and only asking the physician to re-evaluate or reduce the dose. It would be beneficial if the physician was provided with support or recommendations and ways to help or correct issues identified by insurers looking at claims data and other sources. Some MCOs are developing internal programs in which pain management specialists review these cases quarterly and develop a customized treatment plan.[4] That plan should be coordinated with the primary care provider (PCP) to provide that PCP support to better manage the patient. Many patients and prescribers alike don't even understand the importance of having a contract if the patient is going to be taking chronic opioid pain relievers. For the safety of the practice, as well as the member, contracts must be developed. If prescribers do not have contracts in place, MCOs could provide sample contracts to offer additional support to these physicians.

The development of a pain management program needs to be a team approach. The patient is the primary stakeholder in the treatment. Physicians should implement and utilize guidelines and contracts to achieve successful outcomes. A team approach between the MCO and physician will allow patients to be better monitored and enabled to obtain more positive outcomes. If patients require more resources to achieve that, they should be identified and made available. Physicians must be educated on resources available in the treatment of opioid dependence, including tracking different opportunities.

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