Buprenorphine in the VA (BIV Project): Improving Implementation and Outcomes of Office-Based Opioid Dependence Treatment in the VA

A Tool for Buprenorphine Care

(A series of monthly newsletters about buprenorphine treatment)
Volume 2 Issue 9—April 2009

VA Physicians and Patient Limits

Q: Do veteran patients count toward the provider's 30- and 100-patient limit?
A: The short answer to this question is yes, if the provider is using their own Drug Enforcement Agency's DATA 2000 credentialed license to treat their patients with buprenorphine for opioid dependence. For example, if a provider is treating 15 patients in a private practice and also treating patients in the VA, then the maximum veteran patients that this provider can treat with buprenorphine – at any one time – is 15 [if provider patient limit is 30] and 85 [if provider patient limit is 100]. For providers treating patients in opioid agonist treatment programs [e.g., methadone programs] and prescribing using the facility's DEA license, then these patients that are prescribed buprenrophine may not count against the providers individual DEA, DATA 2000 patient limit. In this scenario, the individual provider's limit either 30 or 100 (in their own license) and the facility's limit (on the facility's license).

World Health Organization Position Paper

The World Health Organization, along with the UN Office on Drugs and Crime and Joint UN Programme on HIV/AIDS, has developed a statement on substitution maintenance therapy for the treatment of opioid dependence. It addresses several pharmacologic treatments, cost effectiveness, factors influencing treatment outcome, and special considerations for people with HIV/AIDS, among other topics. Download the statement here [PDF].

From the paper:
"There is mounting evidence that improved outcomes from opioid substitution maintenance therapy arise from timely entry into treatment, longer duration and continuity of treatment, and adequate doses of medication."

"Substitution maintenance treatment is an effective, safe and cost-effective modality for the management of opioid dependence. Repeated rigorous evaluation has demonstrated that such treatment is a valuable and critical component of the effective management of opioid dependence and the prevention of HIV among IDUs [IV drug users]. "

Research Update

- Netherland, et al. **Factors affecting willingness to provide buprenorphine treatment.** J Subst Abuse Treat. 2009 Apr;36(3):244-51. [Epub 2008 Aug 20.] PMID: 18715741.
- Spiller H, et al. **Epidemiological trends in abuse and misuse of prescription opioids.** J Addict Dis. 2009;28(2):130-6. PMID: 19340675.

Tip of the Month

Buprenorphine's ceiling effect may keep it from being effective for patients with higher levels of physical dependence on opioids. However, for providers wishing to switch a patient from methadone to buprenorphine, the methadone dose should be tapered to a methadone dose lower than typical levels of methadone used for methadone opioid agonist therapy. Current recommendations suggest that a patient should be stabilized on a dose about 30mg of methadone for one week.

Next in-service: Buprenorphine and Pain Syndromes—May 29

Semi-monthly cyber in-services. Save the date (and spread the word)!

Our next buprenorphine in-service, *Buprenorphine and Pain Syndromes*, will be held on **Friday, May 29** at **2pm (ET)**.

To add it to your Outlook calendar, click here.

To view slides and submit questions during the meeting, log on to Live Meeting here: https://www.livemeeting.com/cc/vaoi/join?id=bupandpain&role=attend and enter meeting ID *bupandpain*.

To hear audio during the in-service, dial 1-800-767-1750 and enter 13881#.

The official Outlook invitation will be sent soon.

Did you miss the last in-service about starting a clinic? Email Margaret Krumm at margaret.krumm@va.gov to request the Windows Media File containing slides and audio.

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