Body System: Psychogenic

Session Topic: Assisting Patients with Opioid Use Disorder (OUD) Treatment

Educational Format		Faculty Expertise Required
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	Learning Objective(s) that will close the gap and meet the need	Outcome Being Measured
• Many family physicians are not familiar with the DSM 5 criteria to diagnose opioid use disorder. • Many family physicians continue to use outdated language like "opioid abuse" and "opioid dependence" instead of the DSM 5 diagnostic term, "opioid use disorder." • Many family physicians are not aware of the FDA-approved forms pharmacologic opioid use disorder treatment, or the evidence base behind these medications. • Many family physicians are not familiar with how to help a patient determine which type of OUD treatment may be best for them	1. Describe the DSM 5 terminology and diagnostic criteria for opioid use disorder. 2. Summarize effective implementation of *Screening, Brief Intervention, and Referral to Treatment* (SBIRT) strategies. 3. Compare and contrast FDA approved medications to treat opioid use disorder. 4. Develop an action plan that outlines how you will screen individuals for opioid use disorder and how you will respond when screen is positive.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

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• Only 3.6% of family physicians have obtained DEA authorization to prescribe buprenorphine. • A key barrier to providers prescribing buprenorphine is their perception that they are unable to provide adequate counseling or psychosocial support to patients with opioid addiction. • Knowledge gap regarding tools to aid in the assessment of patients they suspect of having addictive behaviors. In the event that patients require referral to sub-specialists for more comprehensive screening, evaluation and/or treatment, family physicians should remain the coordinators of patient care.		

ACGME Core Competencies Addressed (select all that apply)

X	Medical Knowledge		Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources
    - Visit http://familydoctor.org for patient education and resources
- Describe the DSM 5 terminology and diagnostic criteria for opioid use disorder.

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- Explain how use of outdated terminology has been shown to perpetuate stigma, even among clinical providers.
- Describe SBIRT and how it can be implemented in a primary care setting
- Provide an overview of the 3 FDA-approved medications that can be used in the treatment of opioid use disorder and the evidence base behind each of these 3 medications.
- Describe the differences in federal regulations around how each of these medications can be dispensed/prescribed for the use of opioid use disorder.
- Explain how to prescribe naloxone for overdose prevention.
- Provide strategies and resources for developing an action plan that outlines how you will screen individuals for opioid use disorder and how to effectively respond when screen is positive

Needs Assessment

Data from the Centers for Disease Control and Prevention (CDC) reveals opioids (including prescription opioids and heroin) killed more than 33,000 people in 2015, more than any year on record.[1] Key findings of the data from the National Vital Statistics System, Mortality are as follows:[2]

- The age-adjusted rate of drug overdose deaths in the United States in 2015 (16.3 per 100,000) was more than 2.5 times the rate in 1999 (6.1).
- Drug overdose death rates increased for all age groups, with the greatest percentage increase among adults aged 55–64 (from 4.2 per 100,000 in 1999 to 21.8 in 2015). In 2015, adults aged 45–54 had the highest rate (30.0).
- In 2015, the age-adjusted rate of drug overdose deaths among non-Hispanic white persons (21.1 per 100,000) was nearly 3.5 times the rate in 1999 (6.2).
- The four states with the highest age-adjusted drug overdose death rates in 2015 were West Virginia (41.5), New Hampshire (34.3), Kentucky (29.9), and Ohio (29.9).
- In 2015, the percentage of drug overdose deaths involving heroin (25%) was triple the percentage in 2010 (8%).

Deaths from drug overdose have been identified as a significant public health burden in the United States in recent years. This report uses data from the National Vital Statistics System (NVSS) to highlight recent trends in drug overdose deaths, describing demographic and geographic patterns as well as the types of drugs involved.

Reducing opioid-related mortality is challenging because such deaths stem from a variety of patient and physician-level factors.[3] Patient factors often relate to the addictive nature of opioids and thus include misuse or abuse of opioids (prescribed and illicit) drugs, “doctor shopping” to obtain multiple prescriptions, and diversion of opioids leading to illicit sales and abuse. In addition, patient sharing of their pain pills medications with relatives or friends, with little regard for the consequences is common.[3,4] Patients may be driven to misuse opioids by their desire for greater pain relief or to self-medicate comorbid mental health problems or other issues.[4-8] However, family physicians have the potential to be at the forefront of combating this problem. Based on the growing implementation of the patient centered medical home (PCMH) model for patient care,[9] many of these physicians have at their disposal the multiple patient touch points

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needed to identify someone as having opioid use disorder, discuss treatment options and either provide treatment on-site or refer to outside facility for treatment while continuing to coordinate care.

Data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment Survey indicate that family physicians have a statistically significant and meaningful gap in knowledge and skills necessary to manage patients with substance use disorders, including the utilization of risk evaluation mitigation strategies (REMS).[10] More specifically, CME outcomes data from 2012-2015 AAFP FMX (formerly Assembly): *Abuse and Addiction*; *Chronic Pain;* and *Opioid Prescribing* sessions suggest that physicians have knowledge and practice gaps with regard to having an awareness of substance use disorders, including screening recommendations; recognizing one's own biases regarding addiction patients; use of cognitive behavioral and/or motivational interviewing techniques; utilization of urine drug testing for monitoring; thorough and appropriate documentation; effective use of pain contracts; having an awareness of new treatments and guidelines; having an understanding of ER/LA opioid REMS; and using a stepwise approach to pain management and using state prescription monitoring programs.[11-14]

Additionally, while buprenorphine is an effective medication for opioid use disorder that can be provided in office-based settings, only 3.6% of family physicians have obtained DEA authorization to prescribe buprenorphine via a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver, resulting in more than 30 million people living in counties without access to this treatment.[15,16] As such, physicians should keep up to date on new FDA approved medications and devices for office-based opioid treatment, medications that can be prescribed to reverse opioid overdose, and any associated warnings. Including, but not limited to the following examples:[17]

- Suboxone is a combination of two currently marketed medications, buprenorphine and naloxone. It will be used for the treatment of subjects with heroin and opiate addictions. Suboxone and Subutex were the first therapies approved for in-office prescribing under the federal Drug Addiction Treatment Act of 2000.
- Butrans is a transdermal patch formulation of buprenorphine. Buprenorphine is a partial agonist at mu opioid receptors, an antagonist at kappa opioid receptors, an agonist at delta opioid receptors, and a partial agonist at ORL-1 (nociceptin) receptors.
- Zubsolv is a sublingual tablet formulation of buprenorphine, an opioid analgesic, and naloxone, an opioid antagonist. It was designed to counteract the high effect that may arise following the intravenous injection of a disolved tablet. Combining buprenorphine and naloxone in a single tablet reduces the risk of intravenous abuse.
- Bunavail buccal film contains buprenorphine and naloxone. Buprenorphine is a partial aganist at the mu-opioid receptor and an antagonist at the kappa-opioid receptor. Naloxone is a potent antagonist at mu-opioid receptors.
- Belbuca buccal film contains buprenorphine, a partial opioid agonist. Belbuca is specifically indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Physicians may improve their care of patients with substance use disorder by engaging in continuing medical education that provides practical integration of current evidence-based

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guidelines and recommendations into their standards of care, including, but not limited to the following:[18-24]

- Screening for substance use disorders can be performed in the primary care setting with a validated single-question screening tool.
- Patients with hazardous substance use or substance use disorders may benefit from brief counseling by their primary care physician.
- Office-based pharmacotherapy for opioid use disorder using buprenorphine is safe and effective.
- Patients with substance use disorders benefit from identification and treatment of comorbid psychiatric disorders.
- Patients with substance use disorders should be routinely screened for intimate partner violence.
- Cultural and ethnic factors affect patterns of substance misuse and treatment response in adolescents who use substances.
- Motivational interviewing is an effective treatment strategy.
- Primary care treatment for adolescent substance misuse should occur in conjunction with treatment from psychiatrists or other mental health experts.
- Immunoassay tests are the preferred initial test for urine drug screening.
- Positive results from an immunoassay test should be followed by gas chromatography/mass spectrometry or high-performance liquid chromatography.
- An extended opiate panel is needed to detect commonly used narcotics, including fentanyl (Duragesic), hydrocodone (Hycodan), methadone, oxycodone (Roxicodone, Oxycontin), buprenorphine, and tramadol(Ultram).
- Appropriate collection techniques and tests of specimen integrity can reduce the risk of tampering.
- At dosages greater than 2 mg per day, buprenorphine maintains treatment retention better than placebo. At 16 mg or more per day, buprenorphine was found to reduce illicit substance use compared with placebo as monitored by urinalysis.

Additionally, physicians should be aware of current AAFP substance use and addiction policies, generally summarized as follows:[25]

- Recognition of the gravity, extent, and broad-based nature of substance use and addiction in our society, including the development of novel mechanisms to ingest medications and alcohol;
- Inclusion of substance use prevention in patient education;
- Early diagnosis, treatment and referral of those struggling with substance use disorders;
- Recognition of the effects of addiction on family members, especially children, offering support and treatment for family members and inclusion of family members in the treatment of the addicted member when possible; and
- Partnering with community resources in the prevention, education and treatment of substance use and addiction.
- Advocating for inclusion of and parity for substance use treatment in all health care plans;

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- Advocating for legislation and governmental policies facilitating the prevention, diagnosis and treatment of substance use, including funding for further research into substance use;
- Reinforcement of laws and strategies to limit exposure of the population, particularly adolescents and children, to the use and misuse of these substances;
- Supporting harm reduction strategies such as bystander naloxone programs, syringe exchange programs, educational programs and policy initiatives to prevent the secondary diseases associated with use and addiction.

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Physicians also need continuing medical education to understand the differences between Diagnostic and Statistical Manual of Mental Disorders 4th edition (DSM-IV) and the new DSM-V edition, namely the revised chapter of "Substance-Related and Addictive Disorders" which includes substantive changes to the disorders grouped there plus changes to the criteria of certain conditions.[26]

In their role as primary care providers, they can take measures to help to prevent substance use in certain patient populations, particularly adolescents who may be at risk of developing addictive behaviors after early initiation.[27] However, physicians often feel inadequately prepared to meet the needs of these patients. In the largest study on how primary care physicians address substance use disorders, less than 20% described themselves as very prepared to identify alcoholism or illegal drug use, and more than 50% of patients with substance use disorders said their primary care physician did nothing to address their substance use.[22] Primary care practitioners are often called upon to differentiate between appropriate, medically indicated opioid use in pain management vs inappropriate use or addiction; however, primary care providers and their care teams often struggle to balance these risks and benefits with little outside support.[28,29] The literature suggests that a key barrier to providers prescribing buprenorphine is their perception that they are unable to provide adequate counseling or psychosocial support to patients with opioid addiction.[30]

Research indicates that chemical changes in the brain may most profoundly affect adolescents because their brains are still developing; drug and alcohol use can disrupt critical areas of functioning such as behavior control, judgment, memory, learning and motivation. It can also predispose them to addiction later in life.[31] Family physicians can encourage their children and adolescents to participate in science-validated prevention programs, such as: universal programs, which address children in schools or community centers about risks and protective factors; selective programs, which target groups of children and teens who have certain risk factors; and

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indicated programs, which are designed for youth who have already begun abusing drugs. As the National Institute of Drug Abuse states, "while many events and cultural factors affect drug use trends, when youths perceive drug use as harmful, they reduce their level of use."[31] Similarly designed education programs can also benefit older patients who may be at risk of developing substance use disorders.

Addiction to prescription pain relievers, in particular–notably hydrocodone, oxycodone, and morphine–has risen dramatically in recent years; in fact, it is listed as the second most prevalent type of illicit drug use, after marijuana use, among people over the age of 12. The proportion of admissions to substance use treatment facilities due to pain medication use increased fourfold over a span of 10 years (from 2.2% in 1998 to 9.8% in 2008). Physicians who prescribe pain medication should educate patients on correct dosages, safe storage, and proper disposal of leftover medication; they should also be prepared to identify patients with drug-seeking or addictive behavior and offer resources (i.e., referral to treatment facilities or services) to those with substance use problems.[32]

Research also indicates that people with mood disorders–particularly bipolar disorder type II–are at significant risk for developing substance use problems, suggesting that early detection and interventions for patients with mental health disorders may prevent dependence on alcohol or prescription medications.[33,34] Additionally, rates of intimate partner violence exceed 50% in patients with drug use disorders in some settings; it is recommended that physicians screen all patients who present with substance use disorders for intimate partner violence.[22,35,36]

Family physicians should be aware of recent trends in substance use and use in certain patient populations (such as adolescents, young adults, and those with diagnosed psychiatric conditions) in order to be prepared to offer comprehensive treatment plans, often involving a multidisciplinary team approach to care. Family members should also be involved in the treatment of patients with substance use, which family physicians are uniquely prepared to coordinate and oversee.

Patients with a confirmed diagnosis of substance use typically require treatment that includes behavioral therapy, pharmacologic treatment (such as in the case of withdrawal), and occasionally inpatient or outpatient treatment for detoxification or complications.[31] The American Medical Association (AMA)-convened Physician Consortium for Performance Improvement (PCPI) lists the following as performance measures for substance use disorders, which are also endorsed by the APA and National Committee for Quality Assurance:[37]

- Counseling regarding psychosocial and pharmacologic treatment options for alcohol dependence
- Counseling regarding psychosocial and pharmacologic treatment options for opioid addiction
- Screening for depression among patients with substance use or dependence.

Such performance measures are intended to foster accountability among health professionals, as well as enhance quality and patient safety. (However, physicians should remember that clinical decisions about patient care should be made on an individual basis.) As family physicians orchestrate care for patients who require referral to or treatment from sub-specialists, they can ensure patients comply with treatment and return to or maintain an optimal level of functioning and overall health.

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Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Rational use of opioids for management of chronic nonterminal pain[38]
- CDC Guideline for Prescribing Opioids for Chronic Pain[39]
- AAFP Opioid Prescribing for Chronic Pain. Clinical Practice Guideline(s)[40]
- A primary care approach to substance misuse[22]
- Urine Drug Screening: A Valuable Office Procedure[19]
- Adolescent Substance Use and Abuse: Recognition and Management[18]
- Managing Opioid Addiction with Buprenorphine[24,41]
- Buprenorphine Maintenance vs. Methadone Maintenance or Placebo for Opioid Use Disorder[21]
- VA/DoD clinical practice guideline for management of substance use disorders (SUD)[42]
- Interagency guideline on opioid dosing for chronic non-cancer pain: an educational aid to improve care and safety with opioid therapy[43]
- Clinical guidelines for the use of chronic opioid therapy in chronic non-cancer pain[44]
- Thinking on paper: documenting decision making[45]
- Engaging Patients in Collaborative Care Plans[46]
- A systematic approach to identifying drug-seeking patients[47]
- How to monitor opioid use for your patients with chronic pain[48]
- Integrating a behavioral health specialist into your practice[49]
- FamilyDoctor.org: Substance Abuse (patient resource)[50]
- FamilyDoctor.org: Opioid Addiction (patient resource)[51]

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