Treating Opioid Use Disorder as a Family Physician: Taking the Next Step

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The U.S. Department of Health and Human Services has identified opioid use disorder as a national crisis,1 and in August 2017 President Trump declared it a national emergency.2 Drug overdose is the leading cause of accidental injury among U.S. adults, and rates of opioid-related overdoses increased 200% between 2000 and 2014.3 Estimates suggest that drug overdose has emerged as the leading cause of death for Americans younger than 50 years.4 A previous editorial in American Family Physician outlined several important roles for family physicians in combatting the opioid epidemic, with a focus on responsible opioid prescribing and a call for physicians to consider training to prescribe buprenorphine, a medication that can be used in conjunction with behavior therapy to treat opioid use disorder in primary care settings.5 Compared with nonpharmacologic treatment of opioid use disorder, medication-assisted treatment (MAT) with buprenorphine is more effective in reducing opioid use, retaining patients in treatment, and reducing the risk of overdose death.6,7 However, access to buprenorphine-based MAT remains limited.8 Of the estimated 2.5 million adolescents and adults with opioid use disorder in 2012, only 1 million received medication.9 Many physicians who complete the required eight-hour training to prescribe buprenorphine do not go on to prescribe. Reported barriers include insufficient nursing/office support, lack of institutional support, inadequately trained staff, insufficient time, inadequate office space, cumbersome regulations, and lack of knowledge.10,11 Table 1 lists online resources for physicians who are interested in caring for patients with opioid use disorder.

The Agency for Healthcare Research and Quality (AHRQ) recently reviewed 12 models of MAT delivery in primary care settings,

| **TABLE 1** |
| **Resources for Physicians Caring for Patients with Opioid Use Disorder** |

  Provides resources to help physicians overcome obstacles in treating opioid use disorder in rural primary care settings

  Provides information on addiction, practice resources for buprenorphine prescribers, and online and live CME (some free)

- Bup Practice ([https://www.buppractice.com](https://www.buppractice.com))
  Offers training for DATA waivers for physicians and nurse practitioners/physician assistants

- California Society of Addiction Medicine ([http://cme.csam-asam.org](http://cme.csam-asam.org))
  Hosts live and recorded webinars that offer CME (some free)

- Provider’s Clinical Support System for Opioid Therapies ([http://pcssmat.org/education-training](http://pcssmat.org/education-training))
  Offers free training for buprenorphine DATA waiver and hosts live (free) webinars that offer CME on addiction treatment and pain management

CME = continuing medical education; DATA = Drug Abuse Treatment Act.
ranging from office-based teams (e.g., a physician working closely with a “glue person” to help with coordination of services while psychosocial services are provided off-site) to much larger systems of care involving links between subspecialty centers and primary care offices (Table 2).12,13

Most communities are not currently able to meet the demand for treatment of opioid use disorder,8 and family physicians can help fill this gap. The AHRQ review showed that there are different ways in which buprenorphine-based MAT can be safely and effectively delivered in primary care settings. Physicians who do not have

### TABLE 2

<table>
<thead>
<tr>
<th>Models of Buprenorphine-Based MAT for Opioid Use Disorder</th>
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<tbody>
<tr>
<td><strong>Model</strong></td>
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<tr>
<td>Buprenorphine HIV evaluation and support collaborative</td>
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<tr>
<td>Collaborative opioid prescribing model</td>
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<tr>
<td>Emergency department initiation of OBOT</td>
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<tr>
<td>Hub-and-spoke model</td>
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<tr>
<td>Inpatient initiation of MAT</td>
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<tr>
<td>Integrated prenatal care and MAT</td>
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<tr>
<td>Massachusetts nurse care manager model</td>
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<tr>
<td>Medicaid health home model</td>
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<tr>
<td>OBOT</td>
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<tr>
<td>One-stop shop model</td>
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<td>Project ECHO</td>
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<td>Southern Oregon model</td>
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</tbody>
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DATA = Drug Abuse Treatment Act; ECHO = Extension for Community Healthcare Outcomes; HIV = human immunodeficiency virus; MAT = medication-assisted treatment; OBOT = office-based opioid treatment.

Information from references 12 and 13.
on-site behavioral health support often report that they cannot prescribe buprenorphine, but the AHRQ review showed that there are several ways in which psychosocial support and counseling can be provided in office-based settings. For example, one study described a model in which primary care nurses were trained to offer a brief 20-minute weekly counseling session or a more extensive 45-minute weekly drug counseling session.14 Both models had significant reductions in opioid use with no difference in opioid abstinence or retention rates, highlighting the fact that nurses can provide effective counseling in a relatively short session.

Family physicians work in a variety of settings with different levels of staffing, and in communities with varying levels of potential external partners. This review shows that there are models that can fit almost any practice environment, and that there are many potential opportunities for collaboration with external partners.

**Editor’s Note:** The AAFP’s position paper, “Chronic Pain Management and Opioid Misuse: A Public Health Concern” (https://www.aafp.org/about/policies/all/pain-management-opioid.html), serves as a call to action for family physicians, with recommendations and resources for treating pain and managing medication misuse/abuse, including medication-assisted treatment. The AAFP also has a Chronic Pain Management Toolkit (https://www.aafp.org/patient-care/public-health/pain-opioids/cpm-toolkit.html).

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**References**


