Editorials

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

Elizabeth Salisbury-Afshar, MD, MPH, FAAFP, FASAM, FACPM, Chicago Department of Public Health; Rush University Department of Family Medicine, Chicago, Illinois

See related article on page 313 and related editorial at http://www.aafp.org/afp/2017/0915/p357.html.

Published online January 23, 2018.

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

Agency for Healthcare Research and Quality (https://integrationacademy.ahrq.gov/implementing-medication-assisted-treatment-opioid-use-disorder-rural-primary-care-environmental-scan?utm_source=ahrq&utm_medium=dpils&utm_term=&utm_content=1&utm_campaign=ahrq_opud_2017) Provides resources to help physicians overcome obstacles in treating opioid use disorder in rural primary care settings
American Society of Addiction Medicine (http://www.asam.org/quality-practice/definition-of-addiction and http://www.asam.org/quality-practice/practice-resources) Provides information on addiction, practice resources for buprenorphine prescribers, and online and live CME (some free)
Bup Practice (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) Hosts live and recorded webinars that offer CME (some free)
Provider's Clinical Support System for Opioid Therapies (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

Models of Buprenorphine-Based MAT for Opioid Use Disorder

Model	Description
Buprenorphine HIV evaluation and support collaborative	OBOT adaptation in an HIV primary care clinical setting in which a physician prescribes buprenorphine and a nonphysician staff member coordinates care; varying levels of on-site counseling
Collaborative opioid prescribing model	Links opioid treatment programs (facilities that are federally designated as able to treat opioid use disorder with all medications, including methadone) with office-based buprenorphine prescribers; initiation and monitoring are performed at the treatment program, then patients are transferred to a federally qualified primary care health center when stabilized
Emergency department initiation of OBOT	Buprenorphine is initiated in the emergency department, then patients are linked with an OBOT provider
Hub-and-spoke model	Centralized hub provides initial management; when stabilized, patients are transferred to primary care "spokes" in the community; spoke sites have some psychosocial support, which may include social workers and counseling
Inpatient initiation of MAT	Patients identified as having opioid use disorder in the hospital setting are seen by a multidisciplinary addiction consult service; buprenorphine is initiated in the hospital, then patients are linked with primary care clinics for ongoing treatment; psychosocial services are provided on-site in primary care settings
Integrated prenatal care and MAT	Buprenorphine is prescribed in clinic with prenatal and postpartum care; psychosocial services provided on-site or through partnering opioid treatment program
Massachusetts nurse care manager model	Links primary care physicians with nurse managers; nurse managers complete the initial screening and education; psychological services are provided on- or off-site
Medicaid health home model	OBOT integrated model in which behavioral health, primary care services, and MAT are provided in same setting; six core psychosocial services are required, and some telehealth services are offered
OBOT	Physician with a DATA waiver prescribes buprenorphine, and a nonphysician staff member coordinates mental health and psychosocial services; counseling services can be provided on- or off-site
One-stop shop model	Based in integrated mental health clinic that also provides primary care and management of HIV and hepatitis C virus infections; naltrexone (Revia) is the primary medication used; comprehensive psychological services provided on-site, and peer navigators and social workers coordinate care
Project ECHO	Focuses on linking rural primary care clinicians interested in MAT prescribing with a university health system that offers internet-based mentoring and education; counseling is offered at rural health sites and is provided by all team members, including community health workers
Southern Oregon model	Rural primary care network has regular meetings for education and training in opioid prescribing and addiction treatment; each site has a social worker, and coordination/integration of care varies by location

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 Tooklit (https://www.aafp.org/patient-care/public-health/pain-opioids/cpm-toolkit.html).

Address correspondence to Elizabeth Salisbury-Afshar, MD, MPH, at elizabeth.salisbury@gmail.com. Reprints are not available from the author.

Author disclosure: No relevant financial affiliations.

References

1. Macrae J, Hyde PS, Slavitt A. HHS launches multi-pronged effort to combat opioid abuse. July 27, 2015. https://blog.samhsa.gov/2015/07/27/hhs-launches-multi-pronged-effort-to-combat-opioid-abuse/#.WL8h7tLyuUk. Accessed March 7, 2017.
2. Drash W, Merica D. Trump: 'The opioid crisis is an emergency.' CNN. August 11, 2017. http://www.cnn.com/2017/08/10/health/trump-opioid-emergency-declaration-bn/index.html. Accessed August 11, 2017.
3. Rudd RA, Aleshire N, Zibbell JE, Gladden RM. Increases in drug and opioid overdose deaths—United States, 2000-2014. *MMWR Morb Mortal Wkly Rep.* 2016;64(50-51):1378-1382.
4. Katz J. Drug deaths in America are rising faster than ever. *New York Times.* June 5, 2017. https://www.nytimes.com/interactive/2017/06/05/upshot/opioid-epidemic-drug-overdose-deaths-are-rising-faster-than-ever.html. Accessed August 8, 2017.
5. Middleton JL. How family physicians can combat the opioid epidemic. *Am Fam Physician.* 2017;96(6):357-358.
6. Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database Syst Rev.* 2014;(2):CD002207.
7. Schwartz RP, Gryczynski J, O'Grady KE, et al. Opioid agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995-2009. *Am J Public Health.* 2013;103(5):917-922.
8. Jones CM, Campopiano M, Baldwin G, McCance-Katz E. National and state treatment need and capacity for opioid agonist medication-assisted treatment. *Am J Public Health.* 2015;105(8):e55-e63.
9. Volkow ND, Frieden TR, Hyde PS, Cha SS. Medication-assisted therapies—tackling the opioid-overdose epidemic. *N Engl J Med.* 2014;370(22):2063-2066.
10. Walley AY, Alperen JK, Cheng DM, et al. Office-based management of opioid dependence with buprenorphine: clinical practices and barriers. *J Gen Intern Med.* 2008;23(9):1393-1398.
11. DeFlavio JR, Rolin SA, Nordstrom BR, Kazal LA Jr. Analysis of barriers to adoption of buprenorphine maintenance therapy by family physicians. *Rural Remote Health.* 2015;15:3019.
12. Chou R, Korthuis PT, Weimer M, et al. Medication-assisted treatment models of care for opioid use disorder in primary care settings. Rockville, Md.: Agency for Healthcare Research and Quality; 2016. AHRQ publication no. 16(17)-EHC039-EF. https://www.effectivehealthcare.ahrq.gov/ehc/products/636/2350/opioid-use-disorder-report-161123.pdf. Accessed July 30, 2017.
13. Korthuis PT, McCarty D, Weimer M, et al. Primary care-based models for the treatment of opioid use disorder: a scoping review. *Ann Intern Med.* 2017;166(4):268-278.
14. Fiellin DA, Pantalon MV, Chawarski MC, et al. Counseling plus buprenorphine-naloxone maintenance therapy for opioid dependence. *N Engl J Med.* 2006;355(4):365-374. ■