Treatment of Opioid Use Disorder in Primary Care

56th Annual Primary Care Review

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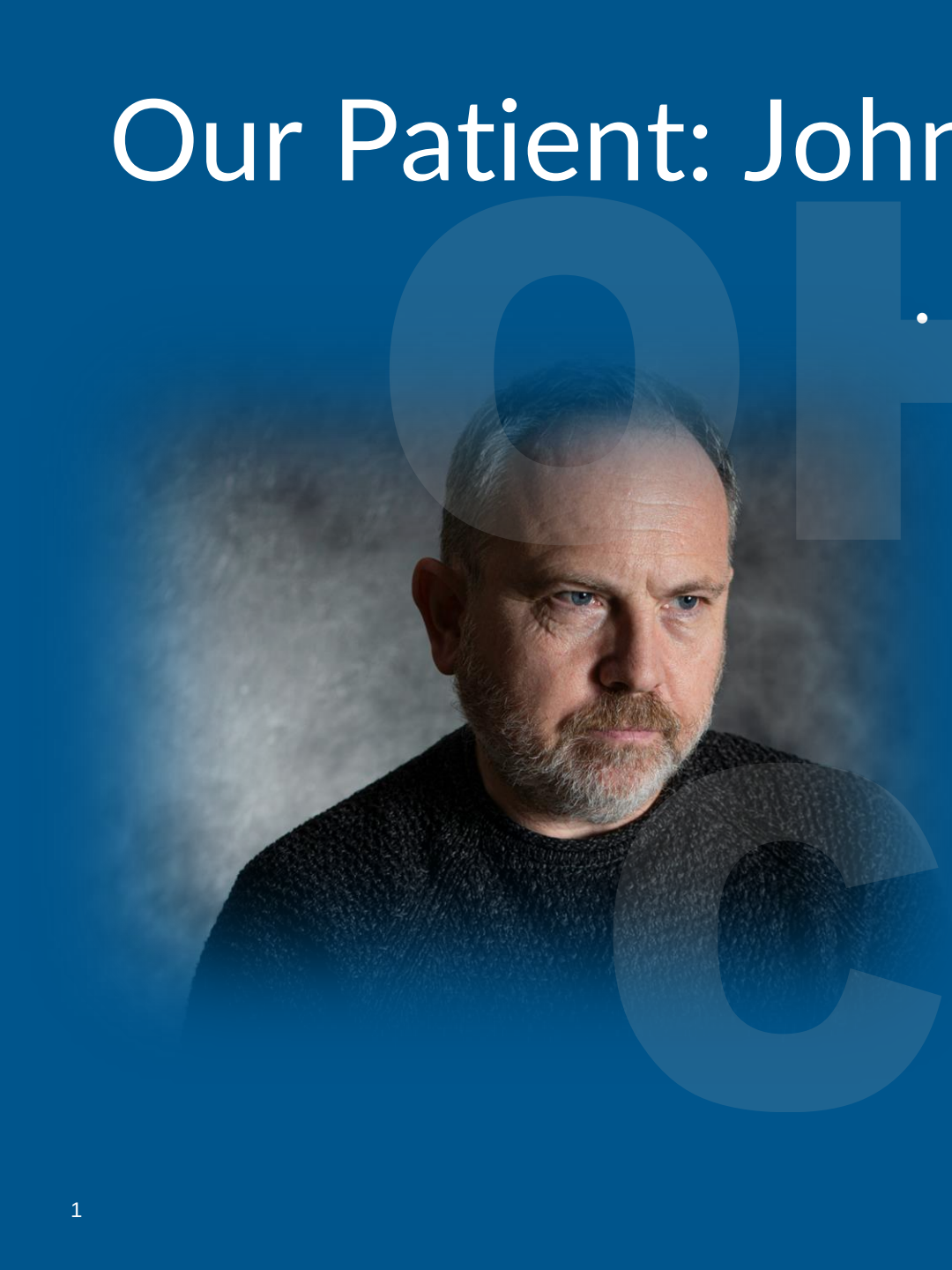
About me

- Board Certified in Family Medicine and Addiction Medicine
- 12 years experience providing buprenorphine management in a variety of primary care settings

What we will cover:

- Why we should treat OUD in primary care
- Basics of buprenorphine
- One method of induction
- Responding to bumps in the road

Our Patient: Johnathan



- 55 year-old warehouse employee with a hx of chronic low back pain from an MVA. You are his PCP.
  - PMHx mild COPD, OSA, Hypertension
  - Has been on chronic prescribed opioids for ten years
    - (10 mg oxycodone TID)
  - Routine urine screen came back positive for fentanyl
    - “I started taking some extra and running out early, and found I needed more and more to avoid withdrawal, so I started buying extra pills from a friend. I’ve been trying to stick with just the ones you prescribed, but if I don’t take the pills from my friend I get REAL sick.”
    - “I need to keep working or I can’t pay my bills, I can’t go to rehab. You gotta help me, doc.”
    - He is taking 5 or 6 “Oxy 30” pills from his “friend”, in addition to the 30 mg of prescribed oxycodone per day.

Diagnosis of Opioid Use Disorder

DSM-V Criteria

Loss of control is the hallmark

Physical dependence alone is not sufficient

Must exhibit one at least one criteria that suggests loss of control

DSM-5 Criteria for Opioid Use Disorder

1	Opioids are often taken in larger amounts or over a longer period than was intended	The presence of at least 2 of these symptoms indicates an Opioid Use Disorder (OUD) The severity of the OUD is defined as: MILD: The presence of 2 to 3 symptoms MODERATE: The presence of 4 to 5 symptoms SEVERE: The presence of 6 or more symptoms
2	There is a persistent desire or unsuccessful efforts to cut down or control opioid use	
3	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects	
4	Craving or a strong desire to use opioids	
5	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home	
6	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids	
7	Important social, occupational, or recreational activities are given up or reduced because of opioid use	
8	Recurrent opioid use in situations in which it is physically hazardous	
9	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.	
10	Tolerance,* as defined by either of the following: a) Need for markedly increased amounts of opioids to achieve intoxication or desired effect b) Markedly diminished effect with continued use of the same amount of opioid	
11	Withdrawal,* as manifested by either of the following: a) Characteristic opioid withdrawal syndrome b) Same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms	

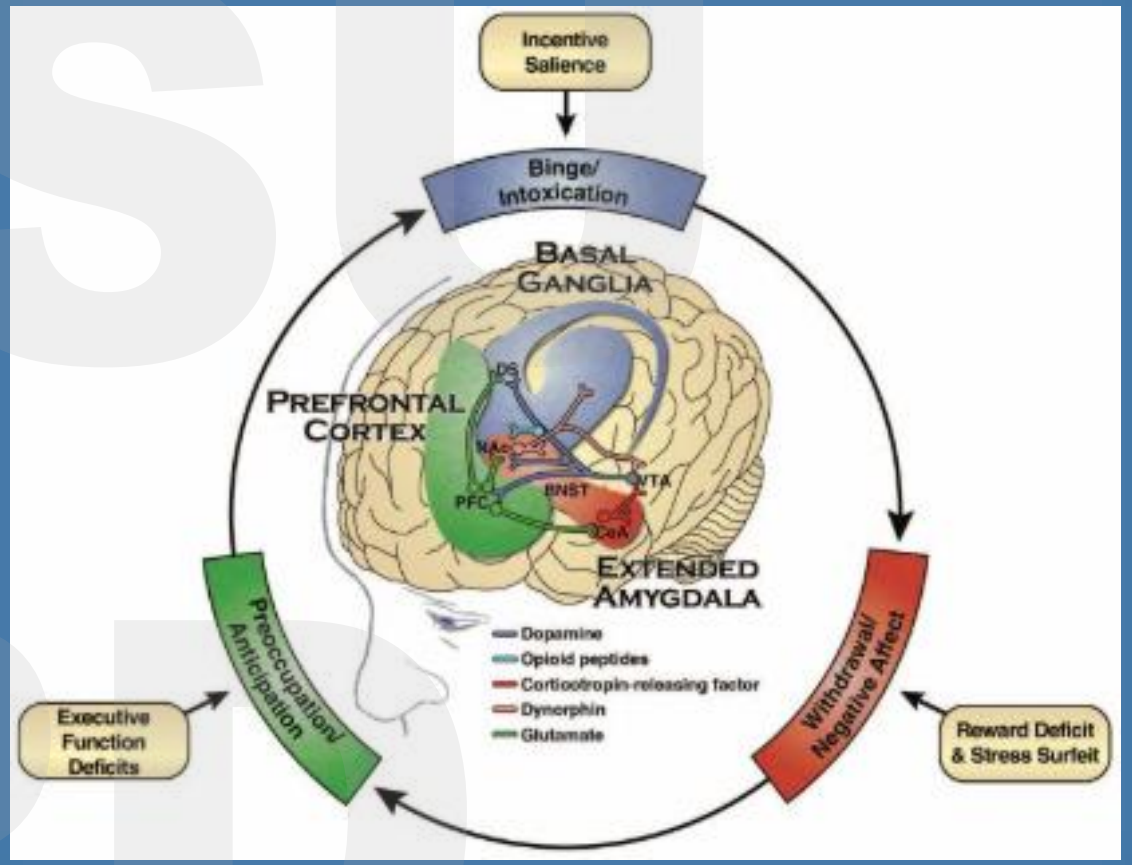
* Patients who are prescribed opioid medications for analgesia may exhibit these two criteria (withdrawal and tolerance), but would not necessarily be considered to have a substance use disorder.

Reference:

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders: DSM-5™ 5th ed. Arlington, VA: American Psychiatric Publishing, Inc.

Opioid Use Disorder is a chronic brain disease[1]

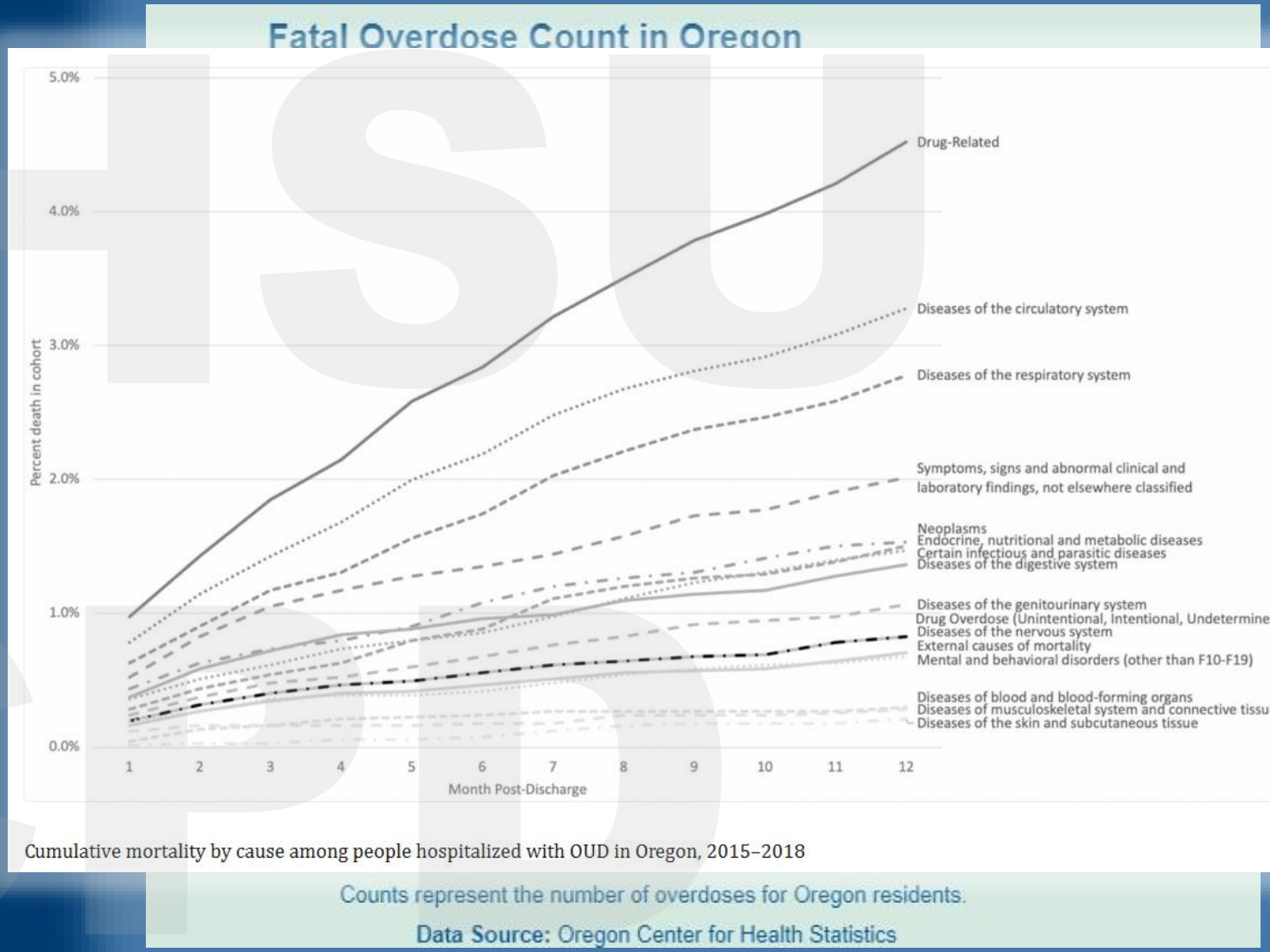
- Removal of the drug of choice is not curative
  - *>90% of people with OUD will return to use after detox without other treatment[2]*
- Structural changes to the brain are measurable and long-lasting
  - Upregulation of opioid receptors
  - Alteration of dopamine reward pathways
  - Decrease in endogenous endorphins



1. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder; Mancher M, Leshner AI, editors. Medications for Opioid Use Disorder Save Lives. Washington (DC): National Academies Press (US); 2019 Mar 30. Summary.
2. Smyth, B. P., Barry, J., Keenan, E., & Ducray, K. (2010). Lapse and relapse following inpatient treatment of opiate dependence. Irish Medical Journal, 103(6), 176-179.
3. Figure from: Andrea Polites, Bruce Sewick, Jason Florin, and Julie Trytek (2024). Illinois SCOERs Addictions Counseling Essentials is licensed under CC BY 4.0.

What are the Health Risks of Opioid Use Disorder?

- Much more than overdose
  - Sepsis
  - Pneumonia
  - Cardiac arrest
  - Metabolic disease
  - Etc. . .
- Overall mortality risk similar to having had a heart attack



King C, Cook R, Korthuis PT, Morris CD, Englander H. Causes of Death in the 12 Months After Hospital Discharge Among Patients With Opioid Use Disorder. J Addict Med. 2022 Jul-Aug 01;16(4):466-469. doi:

Our Patient: Johnathan

The most effective treatment for Opioid Use Disorder is medication ("MOUD")

Table 2. Adjusted Hazard Ratios for Overdose and Serious Opioid-Related Acute Care Use by Initial Treatment Group Compared With No Treatment[a]

Variable	Adjusted Hazard Ratio (95% CI)	
	3 Months	12 Months
Overdose		
No treatment	1 [Reference]	1 [Reference]
Inpatient detoxification or residential services	0.82 (0.57-1.19)	1 (0.79-1.25)
BH IOP	0.81 (0.50-1.32)	0.75 (0.56-1.02)
MOUD treatment with buprenorphine or methadone	0.24 (0.14-0.41)	0.41 (0.31-0.55)
MOUD treatment with naltrexone	0.59 (0.29-1.20)	0.73 (0.48-1.11)
BH other	0.92 (0.67-1.27)	0.69 (0.56-0.85)
ED or inpatient stay		
No treatment	1 [Reference]	1 [Reference]
Inpatient detoxification or residential services	1.05 (0.76-1.45)	1.20 (0.96-1.50)
BH IOP	0.84 (0.54-1.30)	0.90 (0.67-1.20)
MOUD treatment with buprenorphine or methadone	0.68 (0.47-0.99)	0.74 (0.58-0.95)
MOUD treatment with naltrexone	1.15 (0.69-1.92)	1.07 (0.75-1.54)
BH other	0.59 (0.44-0.80)	0.60 (0.48-0.74)

Abbreviations: BH IOP, intensive behavioral health (intensive outpatient or partial hospitalization); BH other, only nonintensive behavioral health (outpatient counseling); ED, emergency department; MOUD, medication for opioid use disorder.

[a] The hazard ratios were adjusted for age, sex, race/ethnicity, insurance type, baseline medical (modified Elixhauser index score) and mental health comorbidities (depression, anxiety, posttraumatic stress disorder, and attention-deficit/hyperactivity disorder), evidence of overdose or infections related to intravenous drug use, and cost rank.

1. Wakeman SE, Larochelle MR, Ameli O, et al. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. *JAMA Netw Open*. 2020;3(2):e1920622. doi:10.1001/jamanetworkopen.2019.20622

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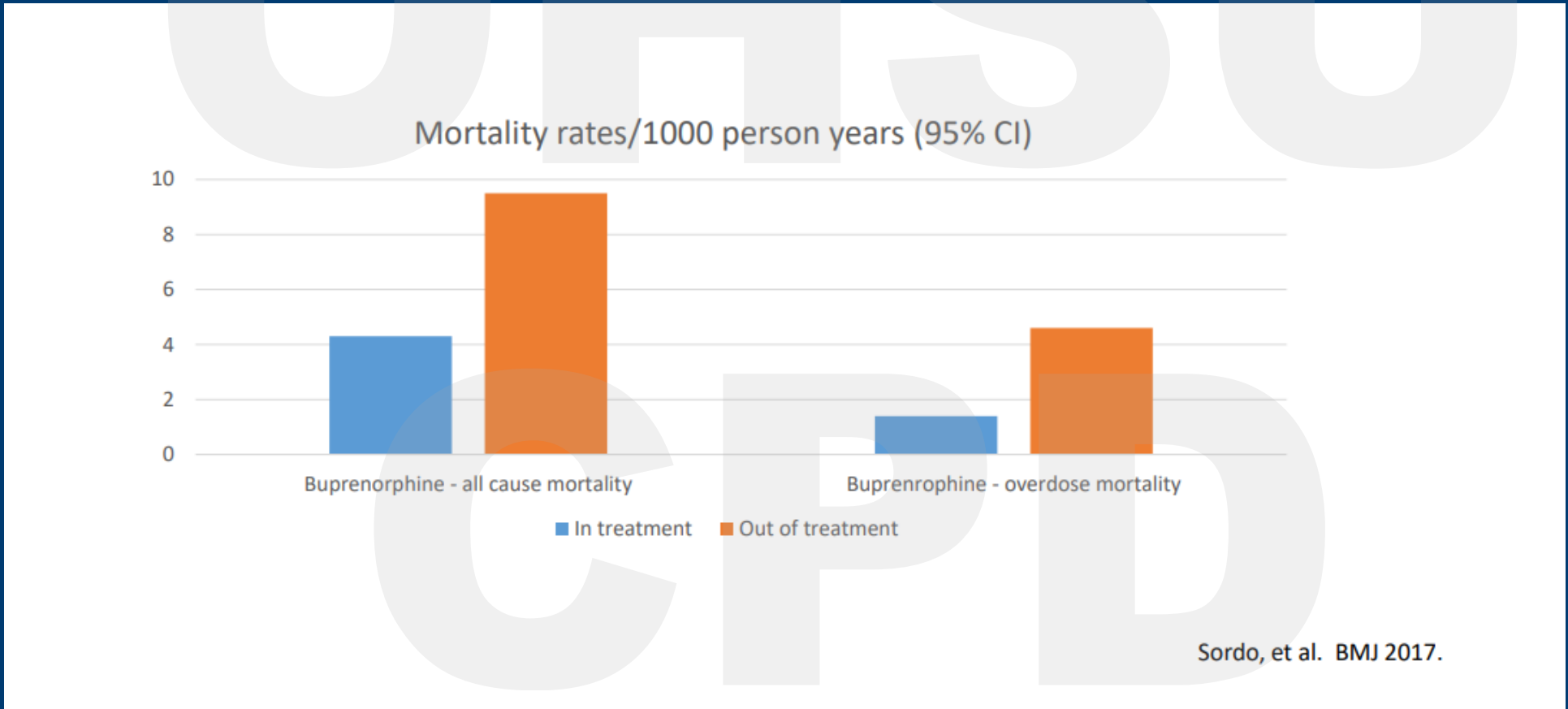
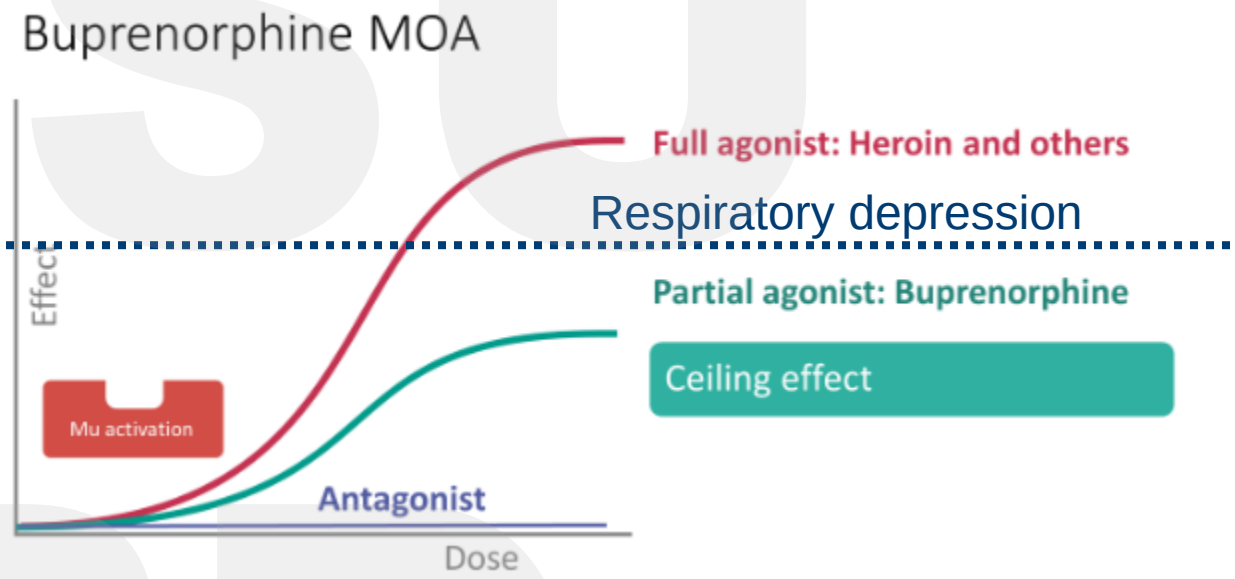


Buprenorphine is. . .

- **A synthetic opioid**
  - Occupies opioid receptors with high affinity
- **Highly potent**
  - 1 mg buprenorphine ~= 40mg morphine
  - Displaces other opioids
- **Long-acting**
  - Half-life of 48-72 hours
- **Partial agonist**
  - ‘Ceiling’ effect limits respiratory depression
  - **Very low overdose risk** when taken by opioid-dependent patients
  - **Can precipitate withdrawal** if started too quickly in patients taking full agonist opioids



Buprenorphine Basics

- **Brand names/forms:**
  - Suboxone, Subutex (sublingual tabs/film)
    - 2mg or 8mg
    - Buprenorphine only active ingredient
    - Naloxone not bioavailable sublingually
  - Sublocade (injection)
- **Dose range for Opioid Use Disorder:**
  - 8mg - 24mg per day is typical
  - 32 mg per day generally accepted ceiling
  - Once daily or divided BID or TID
  - Must be taken sublingually

Buprenorphine Basics

- **The right dose. . .**
  - Extinguishes cravings
  - Prevents withdrawal symptoms
  - Does not cause impairment
  - Can be continued for as long as the patient continues to benefit

Treatment of Opioid Use Disorder: Why We Should Do It In Primary Care

1. Buprenorphine is safe, effective, and life-saving
2. Many patients cannot/will not access care in specialty settings
    1. *Less than 1/3 of patients with an OUD will receive medication in any given year*
3. Medication ALONE provides significant benefit
4. OUD Treatment provided in primary care setting improves engagement in other age-appropriate medical care
5. Supported by the CDC, SAMHSA, ASAM, OSAM

1. D'Onofrio G, O'Connor PG, Pantalon MV, Chawarski MC, Busch SH, Owens PH, Bernstein SL, Fiellin DA. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. JAMA. 2015 Apr 28;313(16):1636-44.
2. Carroll KM, Weiss RD. The Role of Behavioral Interventions in Buprenorphine Maintenance Treatment: A Review. Am J Psychiatry. 2017 Aug 1;174(8):738-747.
3. Haddad MS, Zelenev A, Altice FL. Buprenorphine maintenance treatment retention improves nationally recommended preventive primary care screenings when integrated into urban federally qualified health centers. J Urban Health. 2015 Feb;92(1):193-213.
4. Linking People with Opioid Use Disorder to Medication Treatment (cdc.gov)

Who Should Start Buprenorphine. . .In Primary Care?

- ❑ **My Criteria:**
  - ❑ **Diagnosis of opioid use disorder**
  - ❑ **Currently using opioids** in a risky way
    - ❑ Or **at high risk to return to use**
  - ❑ **Prefers to receive care** in a primary care setting
  - ❑ **Working telephone** and/or means for follow-up
  - ❑ No **uncontrolled benzodiazepine or alcohol use** disorder
    - ❑ Concurrent benzo/alcohol use disorder often safer to do induction in a supervised setting

Buprenorphine Induction: Initial Assessment

- ❑ **Confirm diagnosis of opioid use disorder**
  - ❑ Use DSM-V criteria
  - ❑ Obtain collateral information when available
- ❑ **Assess substances used, route of use, length of time used**
  - ❑ ANY pill bought off the street or 'from a friend' is **fentanyl unless proven otherwise**
- ❑ **Assess for co-occurring substance use disorders**
  - ❑ Stimulant use/MJ use/low-level EtOH use are not contraindications to outpatient induction
  - ❑ Benzo use/high-volume EtOH use may be best for inpatient setting
- ❑ **Assess support system and desired recovery supports**
  - ❑ Stable housing? Other people using in the home? Legal involvement?
  - ❑ Refer interested patients to **behavioral health supports**
    - ❑ Counseling and recovery support is **always offered, but should be patient-driven**
- ❑ **Obtain baseline urine screen**
  - ❑ Can help patients to know what they've been using
  - ❑ Helps you know where they're starting from

A practical guide for buprenorphine initiation in the primary care setting. Roberto León-Barriera, Samantha Jayne Zwiebel, Vania Modesto-Lowe Cleveland Clinic Journal of Medicine Sep 2023, 90 (9) 557-564; **DOI:** 10.3949/ccjm.90a.23022

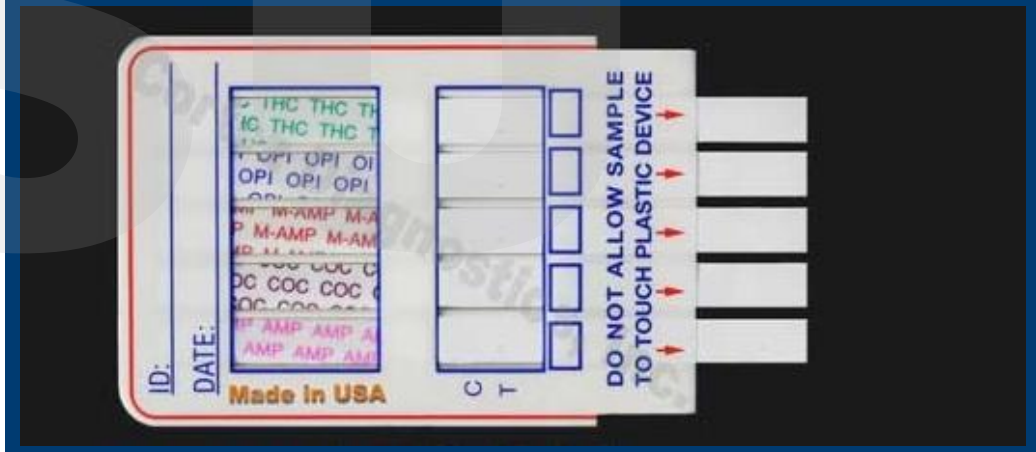
Know your Urine Testing!

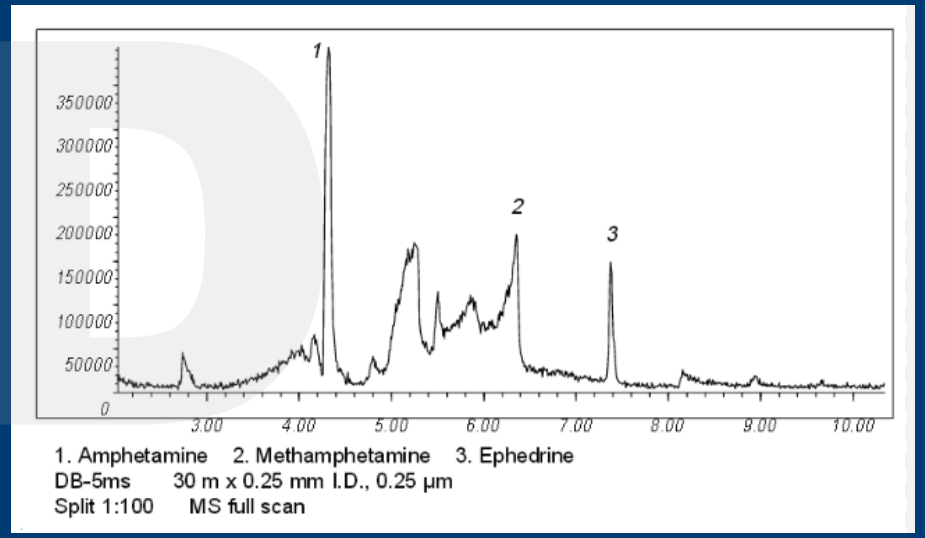
SCREENING test or CONFIRMATORY test?

Screening:

- "ELISA" or "Immunoassay" testing
- All point of care tests
- Many lab-run tests
- +++ false positives (methamphetamine especially)
- Opiates =/= Opioids
  - Opiate screening misses fentanyl and buprenorphine
- Need confirmatory testing for making decisions
- $

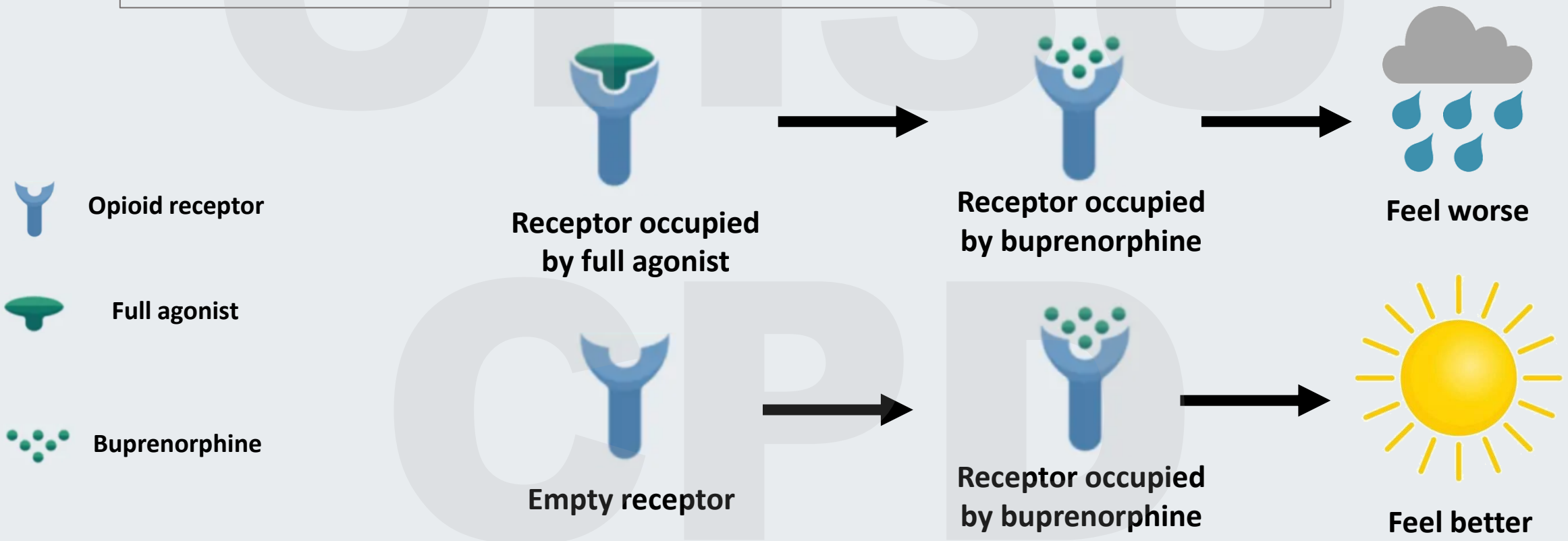
- **Confirmatory**
  - Always done in a lab
  - LC/MS or GC/MS
  - Will return a specific drug rather than a category
  - Often quantitative
  - $$$$$$





Starting Buprenorphine: Precipitated Withdrawal

Abrupt change from full agonist (i.e. fentanyl) to partial agonist (buprenorphine)
= abrupt decrease in receptor activation by full agonist =
withdrawal



Low-Dose Buprenorphine Induction: Tips for Success

- ❑ Provide adjuncts for symptom management
  - ❑ Clonidine
  - ❑ Zofran
  - ❑ Hydroxyzine
- ❑ Start on a weekday
- ❑ Identify home support
- ❑ Prescribe/dispense Naloxone
- ❑ Schedule frequent follow-up
  - ❑ Can be phone/virtual!
  - ❑ Can utilize nursing staff
- ❑ Set realistic expectations
  - ❑ Use of unprescribed opioid likely will continue at first
  - ❑ Success will not be immediate
  - ❑ Success can look many different ways!

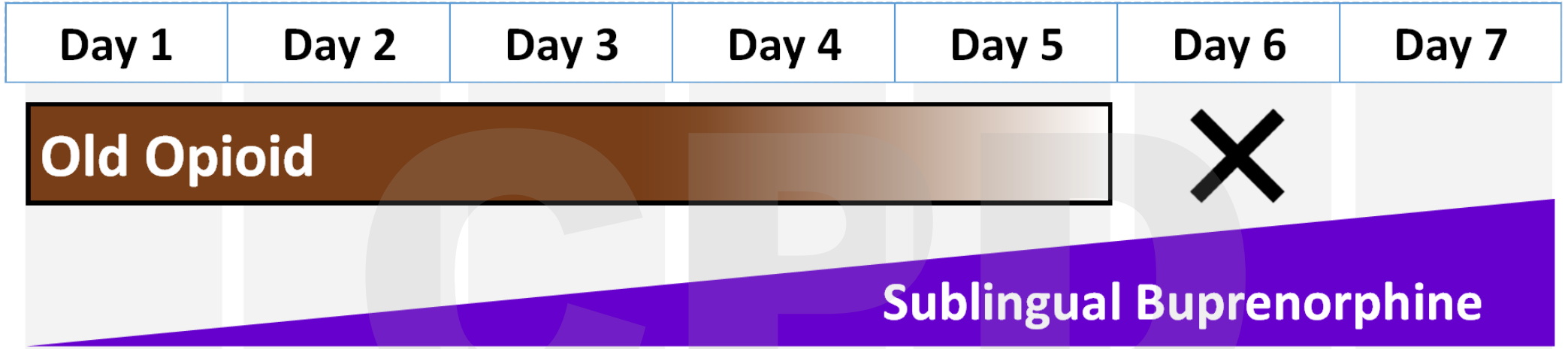
Low dose buprenorphine start

Goal: Start buprenorphine without causing withdrawal

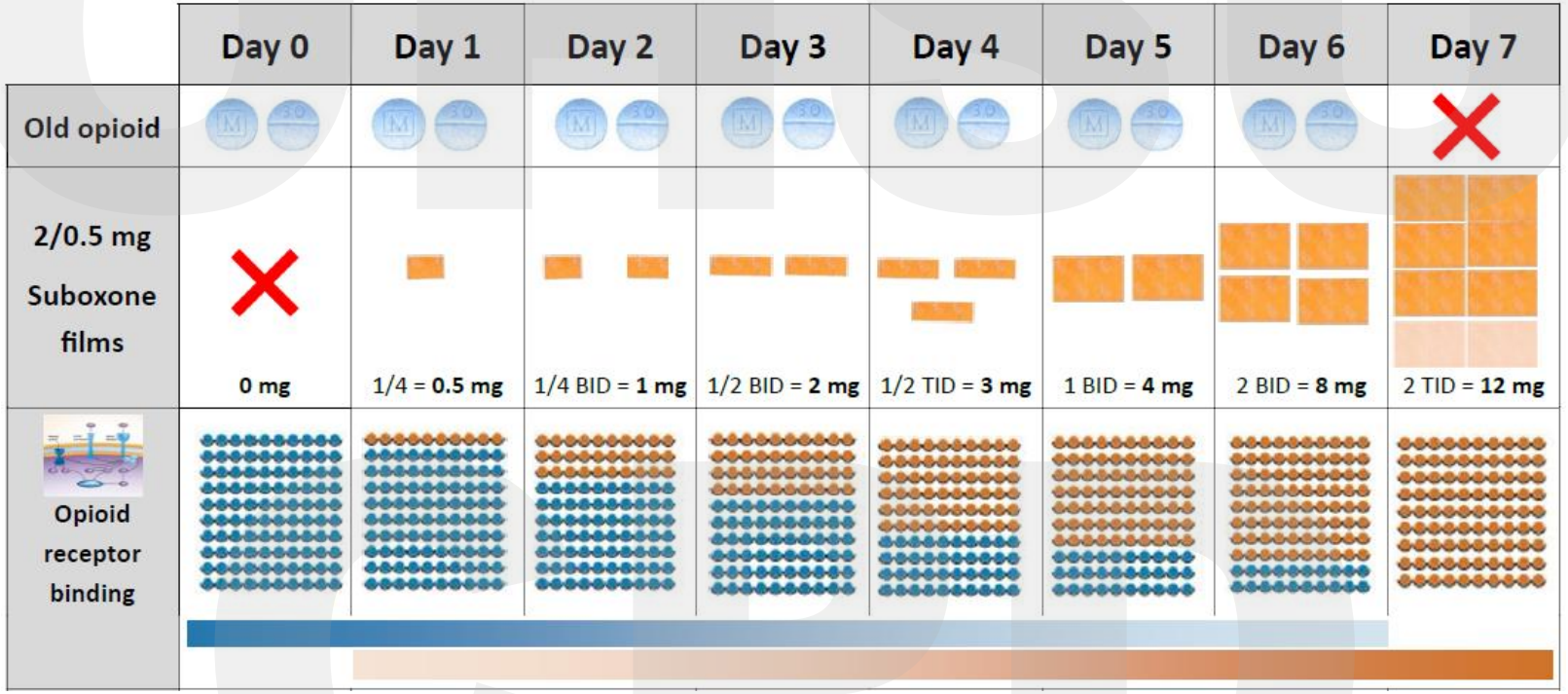
There is no single evidence-based practice

Continue old opioid while buprenorphine dose is increased slowly

JUST KEEP TAKING BUPRENORPHINE



Low dose buprenorphine start



https://bridgetotreatment.org/wp-content/uploads/CA-BRIDGE-SITE-EXAMPLE-Starting-Buprenorphine-with-Microdosing-and-Cross-Tapering-June-2021-1.pdf

How to start buprenorphine (Suboxone) at home without going into withdrawal first

Cut your 2 mg films and take according to the schedule below. Each day you will increase the total amount of medication you are taking. On Day 7 you should follow-up in clinic and begin trying to decrease your opiate use.

Time of Day	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
 Morning	1/4 film	1/4 film	1/2 film	1/2 film	1 film	2 film	2 film
 Afternoon				1/2 film			2 film
 Evening/Night		1/4 film	1/2 film	1/2 film	1 film	2 film	2 film

Buprenorphine: Follow-up Visits

- ❑ How are they taking the medication?
  - ❑ Dose/frequency
  - ❑ Rinsing mouth after
- ❑ Cravings/withdrawal
- ❑ Ongoing use
- ❑ Side effects
  - ❑ Constipation, nausea
  - ❑ Review importance of dental care
- ❑ Assess need for other health care
  - ❑ Cancer Screening, HCV testing or treatment, HIV prevention

Our Patient: Johnathan

- **You stop prescribing oxycodone, and offer buprenorphine induction.**
  - **He transitions from unprescribed fentanyl to 16 mg of buprenorphine**
  - **1 month followup:**
    - Urine test shows only buprenorphine
    - Still working, “no problems, I’m doing great!”
  - **2 month follow-up:**
    - Urine test shows buprenorphine and fentanyl
    - Pt reports he is taking the medication as prescribed, but still getting craving to use fentanyl at night
  - **How do you respond?**

Buprenorphine management: Common Scenarios

What if. . .	How to respond
Urine test is positive for an **opioid**	1. **DO NOT STOP BUPRENORPHINE!** 2. Assess how they are taking the medication 3. Consider dose increase 4. Shorten follow-up interval

Buprenorphine management: Common Scenarios

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Urine test is positive for an **opioid**	1. **DO NOT STOP BUPRENORPHINE!** 2. Assess how they are taking the medication 3. Consider dose increase 4. Shorten follow-up interval
Urine test is positive for a **stimulant**	1. **DO NOT STOP BUPRENORPHINE!** 2. Add other psychosocial supports 3. Shorten follow-up interval

Buprenorphine management: Common Scenarios

What if. . .	How to respond
Urine test is positive for an **opioid**	1. **DO NOT STOP BUPRENORPHINE!** 2. Assess how they are taking the medication 3. Consider dose increase 4. Shorten follow-up interval
Urine test is positive for a **stimulant**	1. **DO NOT STOP BUPRENORPHINE!** 2. Add other psychosocial supports 3. Shorten follow-up interval
Urine test is positive for a **benzo or alcohol**	1. **DO NOT STOP BUPRENORPHINE!** 2. Discuss safety concern with the patient 3. Shorten follow-up interval 4. Consider transfer to a higher level of care if ongoing safety concern

Our Patient: Johnathan

- **You increase Johnathan's dose to 20mg, then 24 mg**
  - **3 month to 6 month followup:**
    - Urine testing positive only for buprenorphine
  - **7 month followup:**
    - Urine testing positive only for buprenorphine
    - Johnathan has gone for routine colonoscopy, where they find early stage colon cancer
    - He is scheduled for a partial colectomy in a few weeks
    - "My surgeon says I need to stop buprenorphine or they won't be able to give me pain medication"
  - **What do you do?**

Buprenorphine management: Common Scenarios

What if. . .	How to respond
Patient has a surgery planned	1. **DO NOT STOP BUPRENORPHINE** 2. Consider pre-operative anesthesia consultation for procedural options 3. Communicate with surgical team pre-op 4. Close follow-up post-operatively
Patient **needs short course of opioids** for acute pain	1. **DO NOT STOP BUPRENORPHINE!** 2. Maximize non-opioid management options 3. Short-term addition of full agonist opioid is okay (in scenario where you would usually prescribe them). 4. Required dose will be higher 5. Length of opioid need should be the same 6. Shorten follow-up interval

MOUD is not the same as chronic opioids for pain

Medication for Opioid Use Disorder (MOUD) [Dx: Opioid Use Disorder]	**Opioid Therapy Plan for Pain [No dx of Opioid Use Disorder]**
Buprenorphine is the **GOLD STANDARD** for treatment of opioid use disorder	Opioids (including buprenorphine) are a **LAST RESORT to treat pain**
Non-adherence to treatment plan or return to use = **ESCALATE** the plan	Non-adherence to treatment plan = **CHANGE** the plan/consider med taper
Higher doses **NOT necessarily riskier** (when alternative is a return to illicit use)	Higher doses ARE **more risky** (when alternative is no opioid use at all)
Flexibility can be offered to improve the chances of treatment success	**Expect strict adherence** to recommendations for safety
Non-pharmacologic treatments are often helpful but may not be required	**Non-pharmacologic treatments** are often more evidence-based and **should be required** for most patients
Co-occurring use of other substances is not a strict contraindication	**Not recommended** if co-occurring use of other substances (no opioid is!)

Further Resources

PCSS-NOW: - **You can sign up for a mentor!** - **Forum for clinical questions!** - **8 hour training available!**	**Buprenorphine Training for MD/DOs (pcssnow.org)** **Buprenorphine Training for Nurses (NP/CNM/CNS/CRNA) (pcssnow.org)** **Buprenorphine Training for Physician Assistants (pcssnow.org)**
Oregon Society for Addiction Medicine CME	Past CME Courses | ORSAM (or-sam.org)
American Society of Addiction Medicine 1h course	ASAM eLearning: Buprenorphine Mini Course: Building on Federal Prescribing Guidance
CA-Bridge - **Warmline: 1-855-300-3595** - Addiction Medicine Consultation Service - Patient and Clinician Resources and Handouts	Resources - CA Bridge
Review Articles	The Next Stage of Buprenorphine Care for Opioid Use Disorder - PubMed (nih.gov) Linking People with Opioid Use Disorder to Medication Treatment (cdc.gov) – read section for Primary Care
Podcasts	#7 Do the OBOT: Buprenorphine for OUD in the Clinic - The Curbsiders
Peer Mentor Services – FOR YOUR PATIENTS	https://www.mhaoforegon.org/evolve

Contact me with questions!

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1. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder; Mancher M, Leshner AI, editors. Medications for Opioid Use Disorder Save Lives. Washington (DC): National Academies Press (US); 2019 Mar 30. Summary.
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8. Cohen et al. Low Dose Initiation of Buprenorphine: A Narrative Review and Practical Approach. J Addict Med 2021 Nov